36394

National Library of Canada
Bibliothèque nationale du Canada

CANADIAN THESES ON MICROFICHE

THÈSES CANADIENNES SUR MICROFICHE

NAME OF AUTHOR/*NOM DE L'AUTEUR* HANSEN BENT EDVARD.

TITLE OF THESIS/*TITRE DE LA THÈSE* COMMUNITY APPROACHES TO THE PROBLEM OF MENTAL ILLNESS

UNIVERSITY/*UNIVERSITÉ* University of Alberta, Edmonton, ALTA.

DEGREE FOR WHICH THESIS WAS PRESENTED/ *GRADE POUR LEQUEL CETTE THÈSE FUT PRÉSENTÉE* Master of Arts

YEAR THIS DEGREE CONFERRED/*ANNÉE D'OBTENTION DE CE GRADE* 1978

NAME OF SUPERVISOR/*NOM DU DIRECTEUR DE THÈSE* Dr. B.K. SINHA

Permission is hereby granted to the NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

L'autorisation est, par la présente, accordée à la BIBLIOTHÈQUE NATIONALE DU CANADA de microfilmer cette thèse et de prêter ou de vendre des exemplaires du film.

L'auteur se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans l'autorisation écrite de l'auteur.

DATED/*DATÉ* 29/3-1978 SIGNED/*SIGNÉ*

PERMANENT ADDRESS/*RÉSIDENCE FIXÉ* P.O. Box 1767
PONOKA, ALTA.
T0C 2H0

NL-91 (3-74)

National Library of Canada

Cataloguing Branch
Canadian Theses Division

Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada

Direction du catalogage
Division des thèses canadiennes

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us a poor photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de mauvaise qualité.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE

NL-339 (3/77)

THE UNIVERSITY OF ALBERTA

COMMUNITY APPROACHES TO THE PROBLEM OF MENTAL ILLNESS

By

© BENT EDVARD HANSEN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF ARTS

DIVISION OF COMMUNITY DEVELOPMENT

EDMONTON, ALBERTA

SPRING, 1978

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Community Approaches to the Problem of Mental Illness" submitted by Bent Edvard Hansen in partial fulfilment of the requirements for the degree of Master of Arts in Community Development.

BK Sinha
. . . .
Supervisor

. . . .

. . . .

Date Feb. 13, 1978

To

my children, and my wife,

whom I missed while working on this thesis.

ABSTRACT

There is a trend to move the mentally ill from the large, institutionalized, mental hospitals back into the community. This was seen as an opportunity and a challenge to the community development agent. It was thought that he could assist the community in facilitating such a move, utilizing his special skills in community development and organizing. At the same time this presented a challenge for him to develop and strengthen a psychological sense of community, thus laying the foundation for a future, more healthy community, in which prevention would be emphasized as compared to treatment and rehabilitation.

In order to assist the community development agent, a discussion and theoretical analysis was presented of such issues as: what is a community ?, what is mental illness ?, and of problems concerning a transition from custodial- to community care. A brief review of community development strategies indicated that primary prevention is the community development strategy par excellence for efficient long-range community development. The opinions and attitudes of community members regarding mental health issues were sought, and some implications of the present state of concern for contemplated community development interventions were discussed. Finally, preventive approaches and some main indications for the role of the community development strategy of primary prevention were suggested.

ACKNOWLEDGEMENTS

I am particularly grateful to Dr. B. K. Sinha for his academic and human support; for his invaluable suggestions assisting me in clarifying clouded concepts, and for his patience and continued interest in my efforts.

I would also like to thank Dr. G. Eyford, and Dr. A. S. A. Mohsen for their contributions to the study.

Finally, I wish to thank those community members of Edmonton, and of Wetaskiwin who indicated their concern for mental health issues in their community by letting me share in their opinions and concerns.

TABLE OF CONTENTS

CHAPTER PAGE

I. INTRODUCTION 1

The importance of community to mental health 3
Traditional meanings of community 7
The changing conceptualization of community 13
The psychological sense of community 17
Research procedures 28

II. CRITICAL EXAMINATION OF RELATED LITERATURE 30

Transition from institutional hospital to community care 30

Deistic and Demonological theories 32
The organic approach - Somaticism 37
Human reform and moral treatment 41
Custodial mental hospitals and institutionalism 47
The community mental health approach 52

The myth of mental illness and models of madness 68

What is mental illness ? 69
Models of madness 75

Acceptance in the community of the "mentally ill" 95

Community care and mental health services in the community 111

Characteristics of community care 119

Catchment area 119
Comprehensive care 121
Coordinated service 122
Emphasis on preventive activities 124

Eight basic service components of community care 127

Consultation and education 127
Emergency services 133
Ambulatory services 136

CHAPTER PAGE

Day/Evening treatment 138
Vocational rehabilitation 138
Social rehabilitation 139
Community residence 139
Hospital care and treatment 140

Community development strategies 144

III. THE PROBLEM AND ITS SETTING 159

IV. OBJECTIVES AND RATIONALE 163

V. STATEMENT OF DESIGN AND HYPOTHESES 178

VI. METHOD AND PROCEDURE 180

Data 180

Subjects 180

Instruments 181
Baker-Schulberg CMHI scale 181
Maclean opinion and attitude statements 187
Mode of referral questionnaire 188

Procedure 190

Data analysis 192

VII. RESULTS 194

VIII. DISCUSSION AND CONCLUSION 249

IX. PREVENTION AND FUTURE TRENDS 275

Preventive approaches 275
People-oriented interventions 284
Social systems-oriented interventions 294

Future trends 304

PAGE

BIBLIOGRAPHY 309

APPENDIX 346

LIST OF TABLES

Table		Page
1.	Comparison of age group distribution in various sources	195
2.	Correlation values CMHI scores / Mode of referral	198
3.	Facilities listed as available by community members	201
4.	CMHI scores in the literature	204
5.	Age groups and mean CMHI scores	205
6.	t - Tests of interpair differences of mean scores for age groups on CMHI scale	206
7.	Comparison of views on potential danger of mentally ill	211
8.	Severity of disturbance in ten descriptions as perceived by community members	216
9.	Items of behavior identified as indications of mental illness compared to factors as mentioned by Costello	218
10.	Utilization of referral sources	221
11.	Analysis of selected items from the Maclean scale	222
12.	Personal characteristics of the mentally ill	224
13.	Comparison of responses to classical descriptions from seven different studies	239
14.	Awareness/Knowledge of facilities now available in the community	243
15.	Expressed 'felt need' for mental health facilities	245
I.	Frequencies for the mode of referral questionnaire	360
II.	Utilization of referral options	361

LIST OF FIGURES

Figure Page

1. Graphic presentation of correlation values CMHI scores / Mode of referral 199

CHAPTER I

INTRODUCTION

It is recognized, that as the community represents the single most important social matrix, which man has invented, and within which he lives his entire life, it plays an essential role in the mental health of man. The community impinges, as an environment, directly upon the individual, imposing its expectations and challenges upon him. It is the community that produces the hazards forcing some individuals to assume the role of the "mentally ill". Too readily have such individuals been segregated (rejected) from the community under pretense of concern for their health, and for provision of efficient and required care for their disorder. Rather it was a desire to circumvent responsibility, and to avoid facing the fact that maybe our community was in need of social change to prevent the occurrence of "mental illness", which made us so hastily welcome the large, custodial mental hospital institutions, often conveniently located far from other human residences. The same prompting made special classes appear in our school system, and established many so-called correctional and reform systems.

For various reasons there is now a 'reverse movement', a movement to transfer back into the community the care of, and the responsibility for the "mentally ill", and all those, we so benevolently (?) are segregating from the community in the name of concern and humanism. The community must face the responsibility for developing in all its members the potentials for coping successfully with the hazards and stresses naturally occurring in any community, that is alive. It is the community itself that has the greatest potential for providing supportive resources to individuals, and for developing existing and new resources among its members with which to meet any challenge and any planning for development.

This is a basic assumption of the community mental health movement, and its overall goal is community development, the development of a psychological sense of community, and a development of all community resources in aid of primary prevention approaches, promoting well-being of all members of the community. This orientation implies loyalty, committment, and a sharing of all responsibility. Therefore, the community itself is responsible for the care of its "mentally ill", and a move to transfer back into the community the care of those now segregated in large custodial institutions, is in progress.

To the community development agent such a move is in absolute agreement with principles of community development, placing the responsibility for evolution of community squarely on the shoulders of each member of the community, and thus also responsibility for the care of its so-called "mentally ill", without allowing for the excuse of segregating such members of the community.

The Importance of Community to Mental Health

Today our modern society is in a severe social crisis. A transformation of life and the World itself has taken place, partly through the introduction of the machine, partly through an accompanying ideology of ambition and achievement. Modern society has become industrialized, and is guided by technology, by which should be understood the system by which a society provides its members with those 'things' needed or desired. Order, integration and equilibrium, it is generally accepted and believed, has been developed in the social organization of society and in the various institutions of society mainly as a corollary to the acceptance of a technological order. However, much of the functioning of this social order and modern technology is not primarily concerned with meeting individual needs; hence human beings are often inclined to deviance and alienation.

Technology, therefore, far from being the blessing to mankind which it could have been, has with the ensuing feeling of alienation, become the most destructive, immediate factor causing a dilution or absence of a psychological sense of community, and as such has caused immense problems concerned with human living to arise. This was particularly felt in the decade of the sixties, which produced events, generating in people, like the great depression of the decade of the thirties did, a feeling that something with society in general and the communities in particular, had gone awry. It was increasingly felt that their communities were becoming more and more unstable, disordered, and unsafe for individuals (Kerner, 1968). The rapid urbanization of the North American continent brought with it riots and race conflicts, student unrest on the campus, crime, terrors of poverty and deprivations. In the Address to the Nation on July 27th., 1967, Lyndon Baines Johnson, then President of the U. S. A., summed it up:

> ... the conditions that breed despair and violence. All of us know what these conditions are: ignorance, discrimination, slums, poverty, disease, not enough jobs. We should attack these conditions - not because we are frightened by conflict, but because we are fired by conscience. We should attack them because there is simply no other way to achieve a decent and orderly society.
>
> (Kerner, 1968, p. xv)

No longer, it seemed, could a sense of community provide emotional and mental calm, nor a feeling of belongingness, human worth and dignity. Alienation, isolation, and the lack of a feeling of kinship was common. People did not feel needed in their community, and only seldom did anyone seriously think about how he or she could contribute to the solution of its problems. Out of this situation has emerged a variety of efforts aimed at repairing the community. These were attempts at slowing down the ravages of social problems, and at strengthening what little was left of a sense of community, mutual responsibility, and help. Industrialization, urbanization, education, environmental pollution, war, crime, racial problems, housing, city planning or the lack of it, poverty - all of these, and many other factors bear importantly on the physical and mental health of people. Thus, today the 'health problem' is virtually synonymous with 'the problem of human existence'. Our efforts, therefore, as physical disorders are at least potentially under control, should increasingly be aimed at mental health, rather than mental illness. This is important, for not only does it allow for primary intervention and for intensified and one can only hope, successful research, but it also opens areas for psychological thinking of concern to the community in its totality, and in relation to areas not generally or hitherto seen as of immediate and direct concern in the existence of man.

Man needs a sense of community. In order to function creatively, and to be able to plan and direct his own life in a condition of mental health and well-being, man needs the primary relationships, the values of status and security, which formerly were available to him in his sharing in a psychological sense of community. However, following the events of the sixties, more than ever before, there no longer was such a sense of community. No more did trust in other humans as humans exist in large measure; shared expectations and confidence were of the past, and man now appeared to face almost exclusively insecurity, instability, disorganization, dehumanization, and alienation. In order to remedy this situation, and to regain the state of mental health in man, the encouraging and strengthening of a psychological sense of community is needed. But because of various factors such as the introduction of machines and technology, and the ideological way that man has chosen, a rapidly increasing number of members of the community have become alienated. Far from feeling themselves to be part of the community or sensing that they understand and approve of this community, they feel set apart from it, unimportant to its functioning and well-being, and impotent to affect it. As Rollo May (1954) said: "they have lost the experience of community", or in other words, they do no longer have a psychological sense of community. This situation poses a major threat to the mental health of man.

In a sick community, man will lack a sense of identity and feeling of competence. He will find it difficult to produce creative thinking. He will approach the world of human interaction with a sense of real despair, and see the attempt to enter into a more fruitful relationship with those around him as betrayal. But:

> The society will be "cured" if it can be changed in such a way that a person is generously and consistently reinforced and therefore "fulfills himself" by acquiring and exhibiting the most successful behavior of which he is capable.
>
> (Skinner, 1974, p. 204)

It is necessary that we foster a sense of community, without which man must wither as a plant without water.

Traditional Meanings of Community

In order to understand what a psychological sense of community is, and how it can be awakened and strengthened, it will be of help briefly to review the main conceptualizations of what a community is, and to suggest a somewhat different way in which to look at the community, a way which may well hold the only hope for the future of community, and for the survival and future direction of mankind itself.

The more generally accepted viewpoint is that a community consists of a certain geographical area, with the people living within this area sharing various institutions and values, together with the relationships between them. This is close to Sanderson's definition:

> A rural community is that form of association maintained between the people, and between their institutions, in a local area in which they live on dispersed farmsteads and in a village which is the center of their common activities.
>
> (Sanderson & Polson, 1939, p. 50)

Such a definition, however, is far from satisfactory. It ignores the existence of other types of community. Slightly more complex is the definition chosen by Roland L. Warren (1963) for his study of the community in America:

> A community is that combination of social units and systems which perform the major social functions having locality relevance.
> (p. 9)

Warren also speaks of community as "clusters of people living in close proximity in an area" (1963, p. 2). Arensberg & Kimball (1965) talk of communities not existing in vacuo, but that each one "occupies its own physical setting, and is spatially surrounded by other communities" (p. 3). The anthropologist, Robert Redfield (1956), also included locality in his definition, and pointed out the existence of communities within communities. He attempted to understand changes which occur as a community goes through the transition from a 'folk' community to an 'urban' community (Redfield, 1941). An important criticism of Redfield was Lewis's critique (1951) of the work in the village of Tepoztlan. Lewis pointed out that a community can be very much urban in some ways, and decidedly folk in others, and the type theory of Redfield fails to shed light on the community which predominates throughout the world today, the community as found in mass society.

Moris Janowitz in the preface to Gerald Suttles' book, The Social Order of the Slum, strongly emphasizes the importance of the physical location of a community, and suggests that: "in this sense territorial boundaries between neighborhoods are a proper element of social structure" (Suttles, 1968, p. vii). Similarly Scott Greer (1962) insisted on locality as a key concept when dealing with the urban community, though with Minar (1969), he also mentions factories, trade unions, corporations, and professions as communities. George Hillery (1955, 1959) examined a number of community studies in order to see what attributes communities have in common. He found and concluded that communities exist in a spatial millieu, and that a minimum agreement must be reached on three characteristics always present when speaking of community. The three characteristics suggested were locale, common ties, and social interaction.

Kaufman (1959) regards the community as a set of goal directed interaction processes engendered by the fact of people's common residence in a locality. Very much similar to Kaufman's perception is that of Sutton and Kolaja (1960 a, b). They, like Kaufman, do not equate community with local society, but they suggest that community involves:

> the policy-deciding, self- or identity-maintaining social system of families residing in a particular area which confronts collectively problems arising from the sharing of the area.
>
> (p. 325, a)

They claim that locality-centered events and activities as reported mainly in local newspapers can be measured in terms of their "communityness". The overall degree of communityness of events taking place within a locality, a rather complex variable with several components, is seen to be an important characteristic of the community. The components include the degree to which the event of activity is locality related, the degree to which the persons involved or influenced by the events are identified with the locality, and the extent to which local people participate in the activity.

Irwin T. Sanders (1966) listed four ways of viewing the community:

(1) as a place to live (qualitative approach),
(2) as a spatial unit (ecological approach),
(3) as a way of life (ethnographic approach), and
(4) as a social system (sociological approach).

Within every instance he chronicled,how almost every observer of community life had his favorite list of changes,which occurred at the local level,and of community characteristics linked to a locality view (Sanders, 1966; especially pp. 464 - 466). A similar review can be found in Warren (1963, pp. 53 - 94).

Thus it can be seen from the literature, that almost all

all approaches to a study and a definition of community have been concerning themselves with the locality aspect as a determining characteristic of community. Several full reviews of community studies, nearly all of which contain varied definitions, clearly support this statement. One could mention Maurice R. Stein's (1960) excellent review of American studies of communities, which contains a dedicated and clear exposition of the Robert Park Chicago school - in spite of the valid criticism of Stein presented by Colin Bell and Howard Newby (1971, pp. 38 - 42, et passim).

Minar and Greer's (1969) book, which though granting that locale is important, suggests that it was more so in the past, than today, is important only in reference to small towns, and primitive villages. A collection of all the studies on the community power structure can be found in a sourcebook, edited by Wirt and Hawley (1968). Studies with a political approach can be found in Terry Clark's (1968) assembly of studies with a strongly theoretical approach. Similarly, one should mention Dennis E. Poplin (1972), whose survey of theories and methods of community research is a fluent presentation. Though not an intensively detailed study, it provides an excellent overview of the area. Also of interest is a small book by Jessie Bernard (1973), in which she, after having given an outline of past studies, calls for a new approach, following upon her reading and understanding of Thomas S. Kuhn (1962), who points out that scientific revolutions are needed and are indeed and in fact now taking place. Kuhn speaks of the community of scientists, which is an example of a nonspatial concept of community. Yet none of the mentioned studies are willing to let go the attachment to the locality requirement for a definition of community. Thus Bernard speaks for them all:

> Although I am loathe to give up the insights of the current critics of our locale-based conceptions of social structure, I am equally loathe to abandon the concept of locale. ... While we are waiting for the revolution, ... we may have to rely on simply tinkering with the old paradigms.
>
> (1973, p. 191)

It appears safe, therefore, to suggest that sociologists have been mainly interested in defining community with respect to place and people. Yet another concept of community includes more the notion of shared institutions and values. This view was perhaps most clearly presented by Lynd's (1929, 1937) investigations of 'Middletown', and those by James West (1945), and A. Gallagher (1961) of 'Plainville'. Emphasis on the importance of such processes as communication, social control, systems linkage, and socialization, has been made by Loomis (1960) in a theory of social systems, similar to the Talcott Parsons' system, applied to the study of community. These approaches nevertheless share a concern with place and geographical boundaries as a central feature of the concept, community.

The Changing Conceptualization of Community

The term, community, is derived from the Latin, communitas, meaning fellowship. This points to yet another meaning of community. In a philosophical sense, community may be used to refer to a moral or spiritual phenomenon. In this meaning one may consider community as a "global village" as referred to by M. McLuhan (1968), though at present this would no doubt make the concept too indistinct and unmanageable. Yet, this is perhaps the only way of viewing community in a truly humanistic sense. Since, as mentioned earlier, there are communities within communities, such a viewpoint should, theoretically, cause no undue strain on the intellect of man, though at present it appears to place severe emotional strain on some, and meet with a very strong resistance. Until such a time that a majority of mankind can accept and comfortably work with the concept of community as a "global village", it may be sufficient to concentrate on far smaller communities, though in a sense preferably in the same universal spirit.

It will be possible to use the old conceptualizations of community, but with community seen from this new perspective. In addition to the older, traditional ways of approach to community, it will be possible to deal with moral or spiritual communities, without geographical boundaries necessarily being emphasized. Such communities may be communities of learned people, professional people, or spiritual communities of various type. They will all share a sense of oneness, of communion, and a psychological sense of belonging. Initially such communities will perhaps be rather smaller than one could desire, but as Robert Nisbet (1960) suggests:

> ... they and they alone can be the beginning of social reconstruction because they respond at the grass roots, to fundamental human desires: living together, working together, experiencing together, being together.
>
> (p. 82)

Then, gradually, as man becomes more skilled and more capable of true community feeling, the community may retain the characteristics as mentioned by Nisbet, though perhaps functioning at a more inclusive, or somewhat 'higher level'.

An interesting and well presented move towards a concern with a humanistic community can be found in Nisbet (1973). Though not a complete turning away from the locality requirement, this work emphasizes the idea of community as not dependent on a narrowly outlined geographical area. Instead, community is seen in the sense of relationships among individuals, characterized by a high degree of personal intimacy, social cohesion, or moral committment. Nisbet comes close to talk of community as a functional unit providing the individual member protection from fear of social void, of estrangement from others, of alienation. Nisbet gives a detailed and exciting picture of the military community from the Greeks to the Chinese of today; the political community from Plato to Hobbes, to Rousseau in the eighteenth century France. He presents a painting of the religious community emphasizing the medieval impact and the later existentialist trend. He deals with the revolutionary community from the French revolution in 1789, through the Russian revolution in 1917, to the revolutions during the 1950's, expressed and explained through the writings and experience of Frantz Fanon. Nisbet then presents a picture of the ecological and plural community, and concludes that:

> ... we can be reasonably certain that the threads of community we have seen persisting for two and a half millenia in the West will continue in one pattern or other.
>
> (Nisbet, 1973, p. 449)

Though often mentioned (e.g. Poplin, 1972; Stein, 1960; etc.) and referred to in most discussions of community, the work of the Chicago school of community studies appears rather superficially understood in general. It may, therefore, be of interest briefly to highlight its main emphasis.

The interest of the school in the city was not a response to specific events, but a long-standing interest in the nature and consequences of industrialization and urbanization. It was seen that the flow to the cities, and the social and family disorganization following this move were factors of great importance in shaping the society and the community in haphazard ways, which increasingly diluted any personal sense of community. Yet this, in itself, was not distinctive of the school - but attempt to take the totality of these problems seriously, and to seek to erect and develop a research program, which could provide a basis for sound programs of social planning and amelioration, was.

The interest in mental disorder was in the nature of a search for an indication or index of social disorganization, and the rapidly withering sense of community. Juvenile delinquency was of interest not just as a social problem, but because without understanding mental disorder and juvenile delinquency, one cannot understand the urban community. The main distinction of this school was that it tried to breathe life into the abstraction, city, and community. There was an awareness in this school of the depth of modern man's psychological sense of anonymity and alienation. Psychology could have benefitted earlier had it sunk its roots deep into this soil. There would not have been for so many years an ignoring of the cultural context in preference for dealing directly and exclusively with the individual. Today, no psychologist would ever suggest that he can understand a person without reference to his family, which is the environment shaping the individual. But even more important is it to see the family itself as embedded in the community. The individual must, therefore, be seen not in terms of his family and other types of group membership, but all of these must be seen in the context of community features, processes, and history.

It was towards this that the efforts of the Chicago school were directed, and it would benefit many disciplines interested in social change and the community to reconsider carefully the work of those involved with the Chicago school. The school thus laid the foundation for a concern with a psychological sense of community. It was concerned with how the modern communities were destructive of the psychological sense of community. Emphasis on location, technology, and the 'thingness' of community has eaten away at the psychological sense of community, until today, many so-called communities are but empty shells, devoid of real life, and rapidly decaying, creating nothing but eventually insurmountable obstacles for the people.

The Psychological Sense of Community

The psychological sense of community belongs together with a different conceptualization of community from the ones earlier mentioned, and at present still holding sway in the academic, as well as in the non-academic world. This new/old concept does not need a location in the spatial sense, nor does it limit itself to a certain number of members, or have special rituals or tests for anyone to be accepted or passed for membership. The community of which we are here speaking has no physical limits, no locality, unless you will - the planet, the globe on which all mankind at present exists.

It is, however, not a kind of maudlin togetherness, a tear-soaked emotional drippiness that misguided do-gooders seek to experience. It is a community sustained by the psychological sense of community in the individuals. The perception of similarity to others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, the feeling that one is part of a larger dependable and stable structure. It is a community defined by the mutual sharing of experiences and communication between members. Thus there is shared interest(s) among members, and an increased communication between them through which they share in each other's experiences. It is indeed a community within communities in the sense that community will be defined in functional terms. Thus a mutual communication, sharing of experience, and interest can exist between for example all community development agents in the World, between all scholars, between all sociologists, psychologists, people of various definite areas of interest, between all individuals who are interested in any possible human topic. An individual will be a member of several or many communities, and there will be a general overlapping and intertwining of all smaller communities, until one day man is capable of thinking and feeling the psychological sense of community with all of mankind. To achieve such a psychological sense of community will require some sacrifice and accommodation on the part of the individual, as well as some capacity of the group to recognize, tolerate, and support the need for individuality. There will naturally be a certain tension or conflict between the groups and the individual, but the decisive consideration for true progress or future survival and development is the maintenance of the sense of community. Within the community, small or large, there will naturally be an effort to establish mutually productive relationships with other communities. In this way a community will no longer be an organizational isolate, but become part of a community of communities - in which the members achieve and have a sense of being part of a network of related and mutually supportive communities. In accordance with one of the basic principles of community development, the linking to other communities, members of any one community will not feel that they are part only of their own community. Their 'sense' would have to have a broader base, if their problem-torn communities are not to deteriorate further.

To explain exactly and precisely what one means by the psychological sense of community is not a straightforward and simple task. Yet, there can be very little doubt,that anyone concerned about our modern society and community knows when they are experiencing the presence or the absence of the psychological sense of community. It is one of the major bases for self-definition and the judging of external events. Today, however, more and more people feel unrelated to and disinterested in what their community (based on locality or not) is, and does. The positive sense of belonging to a community, to see everything that exists within the community, this sense has become diluted and few feel themselves willing to be part of the larger community. It has been suggested that we must look at community in terms of locality boundaries, must insist on small areas, where a high rate of face to face contact can take place, and where it is not difficult for anyone to know a lot about how the community works. When this neighborhood, or 'community', increases in size, it is suggested, we are no longer capable of sustaining a psychological sense of community, let alone a real community. Perhaps it is exactly this viewpoint that holds back the designing and creation of new communities. The question is not concerning growth per se, but a type of growth not governed by the value of maintaining and bolstering the psychological sense of community. How did it happen that our communities permitted a type and rate of growth that destroyed for so many people the psychological sense of community ? We have allowed growth to take place which has made it impossible for an increasing number of members of community to feel themselves part of it, to understand and approve it. The legal-political-administrative entity became ruled and directed by material thinking, politics, and technology almost exclusively. As a result divorce rates have increased, the force of institutional religion and morality has declined, and we have achieved high-rise living quarters, ever-changing neighborhoods, and a fantastic rate of moving, and at last, it seems, the almost complete absence of a stabilizing sense of community. This gives rise to a feeling of alienation, to disordered thinking and acting, to increasing anxiety, and to the feelings of hopelessness and apathy.

Attempts at solving this problem have failed mainly because the problem was seen as being a peculiarly individual problem only, of intrapsychic origin. To solve the problem there must be a shift to an understanding of and concern with larger social contexts, to see the individual as embedded in grouping of family, friends, fellow-workers, neighbors, religious-fraternal groups, etc., etc.. It is these that give structure and meaning to his daily life; it is these, whose quality and force become a function of community. From these groupings can come a positive sense of community. Community structure and force cannot be ignored.

To regain a psychological sense of community, to regain for mankind a positive growth and development, the possibility of survival, and a capacity for conscious decisions as to whither in our future, we must repair the disintegrating seams of the community, strengthen the feeling of interrelatedness and interdependence - we must develop again community in the sense of communitas. Such is the challenge and task, the community development agent has accepted. His presence and his intervention is most timely now, and much of what early occupied the efforts of 'community development workers' was a direct reaction to this decline in the psychological sense of community. Community control, citizen community participation, and the fantastic appeal of the group dynamics approach (groupiness and togetherness) are in fact an expression of the need for a psychological sense of community.

In 1948, Skinner's _Walden Two_ was first published, and somewhat surprisingly became widely accepted, though Skinner's behaviorism is less than popular both within and without the field of psychology. The appeal of the book, however, comes from Skinner's passionate and decisive analysis of modern society, and as again stated in his _Beyond Freedom and Dignity_ (1971), his passionate plea for a society, which will restore in its members a psychological sense of community. The welfare of the community must take precedence over that of the individual, because only through a shared sense of community will the creative potential of the individual and the community reach expression. Skinner wants to go beyond freedom and dignity, and if one wants to go beyond Skinner's "science of behavior", one finds oneself at the point where so obviously Skinner starts, and where he must be, and is, joined by the community development agent of today: the need to develop a psychological sense of community within which belongingness and growth are not incompatible (Sarason, 1974, p. 275). Skinner makes the valid point that our fascination with what goes on inside the heads of people has made us pretty poor observers of environments and those aspects of the environments which relate to and maintain overt behavior. This is a point that Roger Barker (1963, 1968) has made over the years, and to which he has devoted a lifetime of research. Whereas Skinner has spent a lifetime looking at individuals (animals in a Skinner box especially), Barker has focused on a single community and has illuminated how complex and time-consuming is the process of description, let alone of understanding. The work of both Skinner, and of Barker, deserve much and intensive study by anyone truly interested in community.

What is then, in fact, needed to foster and develop this psychological sense of community, to strengthen and stabilize community in this new sense, and to create the conditions in which people can experience a psychological sense of community, i.e. a perception of similarity to others, an acknowledged interrelatedness and interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, and the mutual feeling, that one is part of a larger dependable and stable structure ?

We need today to turn away from the material, technological values of the past, and from the exclusive focus upon the individual.

The community development agent's interest in and concern for the psychological sense of community, and his understanding of the person-environment relationship, makes him of central importance for the future of mankind. He must make systematic efforts at introducing a change in individuals, social systems, populations, or networks of social systems, and institutions, which has as its desired end the improvement of the individual-environment fit. We must examine present systems, their relationships with one another, and their user populations, examine the network-user fit, and then try to modify the different systems and their relationships to improve this fit. There should eventuate a better accommodation between the system and its population. If existing systems can not be modified, we must not hesitate to design new, experimental social systems (Fairweather, 1967, 1969). Thus the community development agent must study the transactions between social systems networks (various functional communities, etc.), populations, and individuals; he must develop and evaluate intervention methods in order to improve person-environment "fits"; he must design and evaluate new social systems, and from such knowledge and change seek to enhance the psychosocial opportunities of the individual.

For the community development agent the term, community, is always related to the intervention target. No longer will community be limited to geographical locality, but will be entirely determined in functional terms corresponding to the level, at which intervention is taking place. In this sense, community will refer to that environment (usually of people) which has some functional relationship to the particular consistent network concerned of interacting relationships between persons, with the persons considered as units of the social system, above and beyond their individual characteristics, and to the next higher system having direct power or control over it (Reiff, 1968; Straus, 1962; Sarason, 1967).

Such a challenge as here inherent, involves the concern with the total community, and thus with the fate of those we have chosen to designate the "mentally ill". As there is now a trend to reintegrate these individuals into the community, it becomes the task of the community development agent to facilitate and to encourage such a change.

Briefly stated, community development is an approach, which for various reasons subscribes to the idea that a community, whatever may actually be meant by this, is a desirable and necessary aspect of human existence. It is, therefore, concerned with the development, encouragement, and maintenance of a particular quality and dimension of social experience, namely the community, and with developing and strengthening a psychological sense of community. As community development is concerned with the total community, it must concern itself with those who have been and are becoming segregated and rejected from the community - thus the concern about bringing the "mentally ill" back into the community. By this is meant to accept the "mentally ill" as full members of the community, and not just as located in the community. Such a move might aid in restoring the sense of responsibility, the members of a community can have for their own fate. It may bring back a sense of integration, free participation, and a sense of membership, which will do much to restore a psychological sense of community, and to reverse the devastating effects generally in the communities of the process of deindividuation and dehumanization.

The community development agent, therefore, will want to obtain information concerning the present state of attitude toward mental illness, and the "mentally ill", as it is held by members of the community. He will seek to find out the values, attitudes, perceptions and life style of the community members. Also of interest to the community development agent is a knowledge of the ideology concerning mental illness generally subscribed to in the community. This would be of immediate importance for selection of community development strategies, that will ensure the acceptance back into the community of the "mentally ill", as well as proper and adequate facilities for the required continuity of care, wherever needed.

How much the general public accepts the assumption that the patient could be better off in the community (Wing and Haily, 1972; Hogarthy and Goldberg, 1973) will be of importance for the psychiatric patient's reception in the community. To accept the transition from hospital care to care in the community as desirable is linked to a consideration of the similarity in the ideologies underlying the community mental health movement, and the community development approach. To assess the attitude of the members of the community, their preferred model of mental illness, and preferred mode of referral, and to consider possible community approaches, which can be used in the attempt to facilitate such a transition, and future preventive community development interventions, is of utmost importance to the change agent, and has implications for the choice of community development methods to be utilized.

The change agent (the community development agent) must not only consider the necessary development with the general public, i.e. those not in a segregated position, but must also consider such effort as may be needed to sustain the mentally ill's motivation to return back to the community, to develop his/her skills as in rehabilitative efforts, and in general seek to aid in the development of the whole being within the social matrix of the community, in order to strengthen the psychological sense of community.

Thus in accordance with community development principles, the change agent will be concerned with a transition from custodial hospital care to community care in that such a move,

(a) strengthens horizontal linkages in the community,
(b) directly attempts to counter alienation, segregation, and estrangement of the "mentally ill" from the community, and
(c) attempts to give expression to the community development principles or values of fraternity, participation,

membership, responsibility, communality, and individuality - relatedness, rootedness, and a sense of identity.

Research procedures

Empirical research is without question the best method for determining variables in mental health, as well as in other areas of concern. For various reasons, however, it is not always possible to undertake exclusively such empirical research. In such cases other procedures, either by themselves or in addition to some empirical research, may be utilized.

Since this study is concerned with attitudes to mental health issues, referral modes, and questions concerning community care and primary prevention in community mental health, it involves both theoretical and empirical research.

The research procedure includes a critical review of literature for insight into the problems dealt with in this study:

(a) Community development strategies,
(b) Transition from institutional hospital to community care,
(c) The myth of mental illness and models of madness,
(d) Acceptance in the community of the "mentally ill",
(e) Characteristics of community care,

as well as a detailed and critical discussion of basic service components of community care. On the basis of the critical review of literature, conceptual analyses have been made of several relevant theoretical issues.

The empirical part of this research was concerned with questionnaire study for measuring attitude variables, and the present state of concern in the community for mental health issues, as well as the preparedness of the community for community development preventive intervention. The study used the following instruments:

(a) the Baker-Schulberg community mental health ideology scale,
(b) the Maclean opinion and attitude statements scale, and
(c) the Mode of Referral questionnaire.

A full discussion of these instruments is given in this study, chapter VI, pp. 181 - 190.

CHAPTER II

CRITICAL REVIEW OF RELATED LITERATURE

Transition From Institutional Hospital Care To Community Care

Recently it has become the general consensus that the delivery of services within the mental health area should increasingly be moved away from treatment in large, traditional hospital institutions to treatment and care provided through facilities embedded within the very fabric of the community itself (e.g. Joint Commission on Mental Illness and Health, 1961; the Hasting report, 1972). The direction here taken has been a deemphasis of the large hospital and long-term custodial care, and support given to a more decentralized, short-term, treatment oriented system of mental health services made available in the local community. Thus for example Kirks and Therrien (1975) describe such a reform in mental health service delivery in the State of Hawaii, U. S. A. They indicate how patients are being kept in the hospital for shorter periods of time, and how long-term patients are being moved to community placements. As the authors are especially interested in the fate of a specific group of patients: candidates for long-term hospitalization, they especially discuss the problem of continuity of care, and conclude that the transfer of responsibility from hospital to community has resulted in not greater continuity of care but rather in greater inter-organizational conflict. Nevertheless, community treatment and a planned, complete phasing out of the public mental hospital has enthusiastically been accepted by many citizens' organizations as well as by government.

Greenblatt and Glazier (1975) reviewing the trends in mental health services in the United States of America during the past twenty years find, that with the trend to close the major institutional hospitals, a series of problems arise, the solution of which require careful planning and evaluation, and that "reintegration of the mentally ill into community settings continues to be a major problem" (p. 1137). Thus it becomes obvious that along with the shift to community care, treatment and maintenance, a need for efficient referral to optimal, suitable service facilities for all types of mentally disordered clients, emerges. It can, therefore, be suggested that the issue now is not whether to phase down the institutional, custodial care centers rapidly or slowly, but that of how it can be done whilst at the same time providing adequate community facilities for the continued care of the "mentally ill" (Robbins and Robbins, 1974). For the community development agent it is thus of urgent importance to ensure the success of a move from custodial mental hospitals to treatment in the community, as this will become a part of his efforts to reintegrate all members of the community, and of his efforts to encourage and facilitate the strengthening and development of a psychological sense of community.

Since the early beginnings of man, it has no doubt been a problem what to do with those members who behaved in a disorganized, relatively uncontrollable manner, and especially when their behavior had been such as to cause a threat to the community, and severe distress to its members. Various approaches have been attempted based on the underlying value system of man at any given time. Thus the concern with mental states has been expressed through ideologies underlying life styles, and changing as man progressed in his physical evolution, as fashion changes in most of man's affairs. Not only are such ideologies an expression of accepted explanations of mental disturbance, but they also reflect the mood and attitudes of man towards his own afflictions, and the immediate state of his helplessness and ignorance with regard to the problems challenging him.

Deistic and Demonological Theories

One of the earliest ideologies and attempts at explaining behavior not directly and immediately understood, was a deistic and demonological theory. Gods and Spirits (demons, furies, imps, incubi, and devils) were invoked to explain the behavior noticed in fellowman. Perhaps the earliest treatment suggested by this can be seen in the surgical intervention of trephining as seen on the skull of Paleolithic man, perhaps part of a ritualistic treatment seeking to release whatever spirit was thought to have entered the individual, and was disturbing his mental functioning (Selling, 1943). The ancient Chinese, Egyptians and Israelites all accepted a belief in demons and god(s), and sought to explain sickness, physical and mental, as caused by such sources external to the body, either in the form of direct punishment following upon some wrongdoing, or in the form of possession by evil spirits. The attitudes of the community toward such forms of mental disturbance were in most cases hostile rather than sympathetic. Intervention or regulation, when thought needed, usually would reflect the attitude held, and thus the person afflicted was generally punished or banished from the community. When treatment was thought possible, it was left in the hands of the priests, who logically were assumed capable of special communication with spirits and gods.

In early Greece, the deistic-demonological ideology was strongly adhered to. Thus for example Plato (429 - 347 B.C.) in spite of some of his insights into the psychological importance of emotion in man, returned to the idea of the importance of the divine as an explanation of mental imbalance. Mental illness he saw as belonging at a very low level of humanity, barely above the level of the purely animal. Aristotle (384 - 322 B.C.) on the other hand was a more progressive thinker. Thus, for example, he suggested that it was wrong to categorize reactions as healthy or unhealthy, seeing all psychological reactions as being linked together in a succession of interrelated events. Unfortunately, at the same time he believed that all psychological illness had an organic basis. In this he was in agreement with the enlightened physician, Hippocrates (460 - 357 B.C.). Hippocrates, who spearheaded a new concern about causation rejected the belief in possessions. He not only suggested purely physical causes, but he also concerned himself with environmental factors as possible sources of stress, leading to mental disorder. Mental illness, he thought, was an indication of an unhealthy state of the brain, a corollary to an imbalance of the fluids in the human body reflecting the four principal elements of the universe (i.e. earth, water, fire, and air). The treatment approach generally recommended was that of profuse bloodletting, practised even as late as well into the nineteenth century.

3

During the Roman era superstitions and mysticism again increased in power, and the use of harsh corrective measures in the treatment of the mentally ill was again the dominant approach. Nevertheless, there were some more enlightened approaches recommended as well. Thus for example Asclepiades during the first century B.C. objected to bloodletting and mechanical restraint, and instead suggested a far more humane approach utilizing baths, music, and occupational therapy. Aretaeus (30 - 90 A.D.) suggested that severe mental states are but exaggerations of an individual's preexisting, and normal, personality disposition and temperament. Mention should be made of Galen (130 - 200 A.D.), who also ascribed mental illness to a faulty personality integration, and whose dictum: "treat the illness, not the symptom" did much to influence later approaches to the treatment of the mentally ill.

The advances of the Greco-Roman world toward more humane treatment, and the concept of organic, natural causation, were soon forgotten in Europe, though for a time preserved in the Arab world. Thus according to Page (1971):

> The first asylums and mental hospitals were built in Baghdad, Damascus, and other Near Eastern cities as early as the eight or ninth century. Medieval Europe slipped back to belief in demonic possession.
>
> (p. 84)

There thus followed a return to the ideology of deistic and demonological theories, which saw mental illness as possession with only rarely a hope for treatment. More and more, mental illness became the concern of theology alone. Treatment consisted in finding more efficient methods by which to create discomfort for the demon and his human host in the hope that the demon might release the human individual. Thus from the death of Galen in 200 A.D. up until the middle of the fifteenth century, the impact of religious emotionalism increased not only in regard to the question of mental illness, but in most areas of human culture. As late as the beginning of the seventeenth century can be found Felix Plater (1586 - 1614), who suggested a progressive system of classification of mental illness still believing that the originator of mental illness was the Devil himself. The superstitious belief of the influence of the full moon on mental disturbance (lunacy) was given expression in the fact that institutions for the treatment of the mentally ill for a considerable time were known as 'lunatic' asylums.

Reactions against such ideas began to emerge. A change in the fashion of ideology, a scientific revolution (Kuhn, 1962) began to take place. Concern about a true science of behavior began. More humanistic ideas were presented. Thus for example an argument for social change in attitudes toward treatment of the mentally ill was made by Juan Luis Vives (1492 - 1540), who suggested that gentle treatment would give better results with mentally ill than would harsh condemnation. Breaking the grip of Theology, and thus making it possible to view mental illness as sickness rather than as possession, was the German physician, Johann Weyer (1515 - 1588). His influence and effort to separate mental illness from witchcraft and possession did not last for long, however. The beginning humanistic approach faded away again, giving place once more to the maltreatment of the mentally ill, and to an ideology based upon deistic and demonological beliefs.

The Organic Approach - Somaticism

Throughout the seventeenth century medical science advanced and formed the framework for psychiatry, whilst the philosophical thought of the Renaissance influenced the development of modern psychology. This was the period of the French philosopher, René Descartes (1596 - 1650), when his dualistic belief, that the mind and body were separate, laid the foundation for the psychosomatic concepts of modern medicine. Though it is not here the place for an extensive discussion of the Mind-Body problem, its importance for later psychological thinking as well as for an understanding of "mental illness" and treatment approaches, invites further and serious exploration by the interested person. Therefore, should be mentioned Gilbert Ryle's (1949) rejection of the myth of Descartes' doctrine of the separateness of mental and physical existence. Thought-provoking and stimulating also are Herbert Feigl's (1950, 1958) extensive search into this problem, as well as Joan Wynn Reeves' (1958) historical research of the status of the problem as a prelude to modern psychology.

The fifteenth and sixteenth centuries were dominated by a belief in deistic and demonological causation, and church authorities zealously controlled and established norms for acceptable behavior in all spheres of man's activity. Illness was defined on the criteria of complaints and somatic symptoms, thus excluding misconducts and gross behaviors. The ecclesiastical specialists determined the treatment approaches toward misconducts and gross behaviors crossing acceptable norms, and these were commonly penance, fine, and imprisonment. Burning at the stake was not common in medieval time, but later became the fitting punishment for unrecanted heresy and witchcraft. As the sixteenth century progressed, reactions against the iron-grip and drastic treatment approaches of the Inquisition began to appear. Thus the rediscovery of Galen and other classical writers made it possible for Teresa of Avila (1515 - 1582) to avoid the treatment approach of the Inquisition for a group of her nuns, who had exhibited conduct of a hysterical nature. Basing her defense on the Galenic theory, she pointed to natural causes for the nuns' behavior, and suggested it was not evil, but "comas enfermas", i.e. as if sick. Thus the treatment would move from the ecclesiastical specialists to the physicians. As Turbayne (1960) has suggested, it is a common human tendency to drop the qualifying 'as if', and this, as one might suspect, soon happened, and the physicians could take under their mantle, not only treatment of illness in the traditional, physical sense, but also misconduct and norm violations as illness (Sarbin and Juhasz, 1967).

As the theologians became replaced by scientists in regard to treatment of strange, mysterious gross behaviors and misconducts, the pole of the natural, rational, and humanistic becomes dominant. Man is seen in a state of nature, and as a product of the social order. Now, following the Renaissance, we also see the birth of the idea of progress in history - a relatively new concept for man. The mentally ill continued to be rejected, and are depicted in the literature of the time as expressing the absurd, and irrationality in the human. Thus for example he is depicted in a play as the hypochondriac. The play is by Jean Baptiste Poquelin Moliere (1622 - 1673), Le Malade Imaginaire, written in 1673, being:

> a critical study of the failure to conform to an ideal of urbanity, solid pragmatism, worldly common sense, good taste, and moderation.
>
> (Hugo, 1966)

Treatment approaches to mental illness remained such as in the preceding time, with abuse and maltreatment continuing.

The eighteenth century was distinguished by a concern with attempts at classification of mental illness, very much a result of the medical model of mental illness holding sway. Even though the proliferation of classification systems to some extent hindered true progress as far as treatment approaches were concerned, it nevertheless indicated an increased scientific interest in the problems. From this period should be mentioned the French botanist and physician, Francois Boissier de Sauvages (1706 - 1767), one of whose students were Philippe Pinel. Using a system similar to one used for classifying plants and animals, de Sauvages arranged overt symptoms of mental disease into classes, orders, and genera in such a way as to indicate no less than 2400 different 'diseases'. Pinel, though fully aware of the various classification systems, did not avail himself of these, when he assumed responsibility for the Bicetre hospital. There he devised a much simplified classification, impressed as he was with the more immediate concerns in the patients' daily life (Milton, 1969).

Though treatment approaches had not changed significantly, this period sees the beginning of special hospitals or asylums for the care of the insane, or mentally ill. Britain established rules for the committment of mental patients in 1744, and in 1750, St. Luke's hospital was opened at Moorsfield, England. The first public institution of a similar nature in the United States of America to open its doors to the insane was the Pennsylvania Hospital in 1756. The first specifically mental hospital in the U. S. A. was established in Williamsburg, Virginia in 1773.

Treatment during this period, as until quite recently, was available mainly to those who could financially afford the rather high fees for personal attention. Even today, because of such economic factors, the existence of a truly social psychiatry remains a hope for the future. The large majority of those suffering from mental illness could hope only to receive some kind of care in a few hospitals or prisons, which often were indistinguishable from one another.

Special places for formal treatment of the insane were not brought into existence generally until close to the end of the eighteenth century as briefly mentioned earlier. Conditions in such places were appalling. The patients were kept in darkness, with only inadequate clothing and bedding provided. Often they were undernourished and without attention to their basic needs. These places, in other words, were simply storehouses of human misery, where often the guards would charge a fee for admitting the general public to watch and be entertained by the sight of a madman's antics (Hunter and MacAlpine, 1963). Later these same places would hide and isolate this particular brand of unwanted members of the community. The idea that 'a mental hospital' could and should be a place for treatment rather than just a storehouse for our social misfits, a place for custodial care, was an expression of a beginning change in ideology. During the seventeenth and eighteenth century, the mentally ill had been viewed as having the status of wild animals, and as expressions of irrationality and the absurd. The treatment approach, if one dare so designate the efforts to deal with these helpless beings, was characterized by abuse and mistreatment. Now, toward the end of the eighteenth century protests against such abuse and brutal approaches began to be heard and more humane care and nurture began to appear.

Human Reform and Moral Treatment

Though the organic approach, viewing mental illness as disease, continued to be the dominant ideology, the end of the eighteenth century, and the beginning of the nineteenth century saw some significant suggestions for, and promises of change, emerge. In spite of the belief that treatment was futile until the underlying physical cause was found, demands for more humane care of the mentally ill began to be heard, and reform movements of various kind appeared. One such kind of reform can be seen in the work of Philippe Pinel (1745 - 1826), who, when head of the hospital Bicetre in France in 1793, believed that all the insane needed was: "Fresh air and ... their liberty" (Zilboorg and Henry, 1941). He proceeded to take action according to his convictions, and began to release the mentally ill at the hospital from manacles and chains as were commonly used in this type of hospital of the eighteenth century. Believing that the mentally ill could be thus trusted, and that the mental hospital could be a place for treatment, he attempted to establish a therapeutic hospital environment, based on kindness, humaneness, adequate diet, and general good physical care. He rejected bloodletting and the excessive reliance on drugs and punitive measures as a form of therapy, and recognized the importance of emotional and psychogenic factors for an understanding of the origin of mental illness. Further, in order to study the problem scientifically, he developed a simple classification system with only five categories, and introduced the requirement of keeping detailed case records for each individual patient (Page, 1971).

Similarly in England, reform was underway - one of the best known being the establishment of the York retreat in 1796 by the Quaker, William Tuke. The treatment approach here was based on understanding, affection, and aimed at providing liberty and comfort to the mentally ill. During this period the use of chains became discouraged, though for a long time, it was still thought necessary to restrain the patients by the use of leather straps and straitjackets. The idea of nonrestraint was only spreading slowly and being accepted with some reservations. Most opposition came from the medical circle of professionals. A three-year experiment in total non-restraint was reported by R. G. Hill in 1840. Though the results were excellent, opposition from staff forced Hill to resign. During this period also, John Conolly (1784 - 1866) demonstrated the fact that total abolition of mechanical restraints is possible in a large public asylum. Conolly also sought to establish what has later become known as a 'therapeutic community' (Page, 1971).

Thus it was Pinel, Tuke, and others who towards the end of the eighteenth century introduced moral therapy as a new treatment approach to mental illness. The meaning of the word, moral, at that time compares with the meaning of 'psychological' or 'interpersonal' as used today. The treatment took into consideration social and environmental factors, and consisted mainly in a restraining of the behavior, a retraining or a readjustment to society. This was done by friendly association with the patient, through discussion of his difficulties, and through a daily program of purposeful activity. The moral therapy took place within as positive and sympathetic a social millieu as possible. Patients responded well to the personal interest in their welfare shown by hospital staff. A number of studies (Bockoven, 1956; Joint Commission of Mental Illness and Health, 1961; and Rees, 1957) point out that the results of this new approach compare favorably with the better of today's programs. Thus Rees (1957) states:

> For example in all patients admitted to the York retreat within three months of the onset of illness - between the years 1796 and 1861 the discharge rate was 71% ... These are truly remarkable figures, especially when one takes into consideration that a substantial portion of the patients must have been general paralytics, for which there was at that time no effective treatment.
>
> (pp. 306 - 307)

Though a suspicion that a relationship might exist between Syphilis and mental disorder had been made by Esmarch and Jessen as early as 1857, it was not conclusively determined until the experiment performed by Kraft-Ebbing in 1897. Not until the discovery of the spirochete, Treponema pallidum in 1905, and its presence in the nerve tissues of the paretic in 1913, could the search for preventive and therapeutic methods begin.

Unfortunately, such positive results achieved in the few hospitals in the mid-nineteenth century utilizing the new, more humane approach, moral treatment, were not indications of future results in the mental health field. Even though the effectiveness of moral treatment thus must have been obvious, it was quietly abandoned and literally forgotten in American and British institutions from 1860 onward. Bockoven (1956) points out how recoverey rates at the Worcester State Hospital declined over ninety per cent after 1860, reaching their lowest point between 1923 and 1950 (pp. 292 - 293). In the United States, a schoolteacher from Massachusett, Dorothea Lynde Dix (1802 - 1887), upset over the neglect and brutality prevalent in asylums and almshouses, persuaded legislative bodies to construct large mental hospitals. As a result a change in numbers of those cared for in mental institutions rose from "... 2561, or 14 per cent of the estimated ill in the country (USA) in 1840 ... to 74028, or 69 per cent of those estimated ill in 1890" (Milton, 1969, p. 9).

In the place of moral treatment, which was based on personal contact between patients and staff, treatment became increasingly impersonal. As the hospitals increased in size, the number of patients increased, but not the number of attending psychiatrists and other staff, and treatment became much less effective. Mental illness was seen as disease similar to physical disorders for which no medical cure had yet been found. This too was conducive to the disappearance of moral treatment. It was assumed that techniques effective with physical illness would also be effective with mental illness. As the 'scientific' approach progressed during the nineteenth century, patients suffering from mental illness, which was defined as a medical condition, were treated by mechanistic, impersonal, cold, distant, and unfeeling approaches, which were thought to be consistent with the spirit of the impersonal science. Thus patients were no longer thought of as human beings with problems, but merely as 'cases'. Treatment approaches were rarely less barbaric than those encountered in medieval time. Drug treatment continued mainly in the form of purgatives. In 1917 paretic patients were inoculated with malaria, and for a time this was attempted unsuccessfully as a cure for other psychotic disorders. Barbiturates were used to produce continuous sleep treatment. Then in the mid-thirties somatotherapy became deeply entrenched with the development of Insulin Coma therapy, Metrazol- and electrical convulsion therapy, as well as cerebral surgery of a rather crude nature. The discovery of tranquilizing drugs since 1952 has made the aggressive patient easier to handle in the hospital, but has not brought about the hoped for cures. Until today, the faith in somatotherapy and the expectant search for underlying biomedical causation of mental illness has ensured the dominance of the medical approach to the treatment of the mentally ill. Together with the problems in patient-staff ratio, this invited custodial care and the reappearance of gross neglect of the mentally ill.

Custodial Mental Hospitals and Institutionalism

Thus, during the nineteenth and the early twentieth century, the medical concept of disease became more and more firmly accepted as the valid model for mental illness, and as the search for an underlying organic cause did not meet with much success, the fate of the mentally ill was for them to become the helpless pawns in a waiting game. More and bigger mental hospitals were built to house the unfortunate victims of mental disease, and though some humane thinking still was influential in determining the treatment approach, the mere size of the problem made it increasingly difficult to retain an earlier enthusiasm. To most members of the community the committment of mental patients to locked institutions appeared a satisfactory way of protecting the community. In order to also provide the best (?) for the patients these institutions became conveniently located in the open countryside, preferably as far from the active community as possible.

The number of patients increased, treatment became more and more impersonal, and less effective. Medical staff was inadequate both in numbers and training, and could not do much more than deal with incidental physical illness among the inmates of the mental institution. Attendants were selected more for their size and strength than for any special understanding of mental disorder or for any special interest in the plight of a fellow human being afflicted with so-called mental disease. Treatment approaches in the overcrowded, unhygienic and bizarre world of such institutions were mainly attempts at keeping the patients docile and passively adapting to and accepting the 'treatment programs'. As mental patients were thought to be incompetent, their every move was supervised. They were told when to arise in the morning, when to retreat at night, what clothes to wear, and when and what to do, when and where to smoke, eat, etc.. Walks outside the ward for fresh air were undertaken in groups herded back and forth by attendants. The so-called treatment program was dull, repressive, and arranged to encourage dependency. Such programs tended to fixate and exacerbate disorganized behavior in the patients. In fact, in itself it tended to make the patient's mental disorder incurable.

The result of residing as a patient in such large, custodial institutions has been referred to as 'institutionalism', the establishment of a form of behavioral reaction to the demands of an impersonal and really rigid regime evoked in the individual by the social pressures of the institution. Such pressures generally lead to emotional apathy, lack of spontaneity, and an incapacity for active adjustment to events which are commonplace, everyday events to community members not residing in institutions. The reaction has most commonly been described as consisting of a syndrome, i.e. a combination of apathy, resignation, dependence, depersonalization, and a reliance on fantasy.

57

Several authors have concerned themselves with this concept of institutionalism or some one aspect or other of this condition. Some have suggested that it is the aspect of residence in the custodial mental hospital, that is primarily responsible for converting acute, transitory reactions into chronic, incurable disabilities (Goffman, 1961; Kantor and Gelineau, 1965; and Ullmann, 1967). In this connection, Braginsky, Braginsky, and Ring (1969) bring up the question whether the hospital alone is responsible for institutionalism. They point out that many patients choose continued hospitalization as a career. Some patients, sufficiently well to live in open wards may find that the provision of food and shelter, clothing, medical care, etc., for them without charge, and with entertainment and the opportunity to concentrate on their hobbies, obtainable without much effort on their part is a powerful attraction for remaining in the hospital. Nevertheless, to view the patient-hospital relationship as suggested by the authors:

> ...as a function of a hedonistic calculus where the hospital is seen as a potential pleasure dome and the patient as an architect of his own personal Shangri-La
> (p. 132)

may be to have overemphasized the free choice of a minority of patients. Unfortunately, the majority of chronic patients have received the condition of "institutional neurosis" (Barton, 1959) as a direct result of their stay in the custodial mental hospital.

Of general interest can here be mentioned that Albert Deutsch very clearly and informatively has traced the history of and laid bare the distressing conditions of the mental hospitals of the United States in his two books (Deutsch, 1937, 1948). In a review of studies Paul (1969) points out that with institutionalization established in the mentally ill, and after two years of continual residence in a mental hospital, the likelihood of release to the community and possibility of rehabilitation has become reduced to somewhere about six per cent only. Honigfeld and Gillis (1969) similarly found that the developments of institutionalization in the mental patient is directly related to the duration of the stay in hospital. Though the authors do not show conclusively that the treatment program was successful, Dieter, Hanford, Hummel, and Lubach (1965) demonstrate that brief, intensive treatment is successful based on criteria involving time spent in hospital. A retrospective study of psychotic patients has suggested that post-hospital outcome is inversely related to the length of stay (Mendel, 1966). The methodology of that study, however, is less than elegant. Other, more carefully controlled studies, have not replicated such a finding (Glick, Hargreaves, and Goldfield, 1975). On the contrary, it has been found in some studies (Glick et al., 1974; Durrell et al., 1965; and May, 1968) that psychotic patients with a longer hospital stay had a better outcome than those with a short hospital stay only. It may be that these findings are biased, as it can be seen that the patients treated for the longer time in hospital also were treated more intensively. Pasamanick, Scarpitti, and Dinitz (1967) in a well-documented and careful study, found that schizophrenics who are treated at home may do as well as those who are hospitalized. Kubie (1968), on the other hand, has pointed to what he suggests are fallacies of the belief that the shorter the patient's stay in hospital the better. He suggests that with the brief hospital stay, the psychiatrists become forced to rush the patient through all routine admissions. This procedure is thought in itself to disturb the patient, and thus possibly influence results of tests negatively. Further, because of lack of sufficient, trained manpower, patients are given chemotherapy as soon as they enter the hospital, and this often masks their real problems from the day of admission. As the concept of short-stay becomes accepted, the patient must be rushed through treatment programs resulting in patients being discharged even before proper assessment and test results are available. Yet another study by Caffey, Galbrecht, and Klett (1971) indicates that there are no difference in outcome for the short versus the long term in-patient treatment. It has, however, been suggested that using length of stay as an outcome criteria is built on highly questionnable assumptions and fallacies (Erickson, 1975). Further, Erickson and Paige (1973) pointed out that a 'speed-of-treatment' model has been used, rather than a more desirable and perhaps more indicative 'optimal treatment period' model.

Nevertheless, many carefully designed studies have indicated that much of what patients experience in the hospital can entrench rather than diminish social functioning deficits, the patients may have. The problem goes well beyond the well-documented social regression syndrome with prolonged, custodial mental hospital stay (Barton, 1959; Goffman, 1961; Gruenberg, 1967; and Hansell and Benson, 1971). In such studies, patients have been randomly assigned to full hospitalization versus partial hospitalization (Herz et al., 1971), hospital treatment versus outpatient family crisis intervention (Langsley et al., 1969, 1971), hospital treatment versus home treatment (Pasamanick et al., 1967), and hospital treatment versus immediate placement in autonomous living situations with outpatient therapy (Marx, Test, and Stein, 1973). All of these studies have shown the superiority of alternative intervention to hospitalization with up to three years follow-up.

The community mental health approach

The community mental health movement was in part a response to the belief that hospitalization of the mentally ill was more harmful than helpful, and could in fact cause the illness to become chronic. At the same time, increasing attention was paid to the importance of the social environment for the patient and the emerging belief that he could be better off in the community (Wing and Hailey, 1972; Hogarthy and Goldberg, 1973). Whether rigorous evaluation will prove this to be true or not, there is now within the mental health care more and more an effort towards change to this viewpoint. How much the general public accepts this assumption will be of importance for the psychiatric patient's reception in the community.

During World War I it was discovered that immediate treatment of acute psychiatric casualties without displacement to rear areas and hospitals there, with the consequent delays, led to less need for hospitalization. This experience of military psychiatry demonstrated that brief intervention in moments of stress and breakdown, and in the immediate environment, frequently led to more rapid improvement and diminished chronicity and disability. Thus basically the concept of crisis intervention grew out of expediency and was derived from the military experience. Nevertheless, a basic body of theory has been developed (e.g. Caplan, 1964; especially pages 34 - 55). Early treatment averts hospitalization, and it was soon becoming increasingly accepted, at least theoretically, that if a person or persons suffering from mental disorder received vigorous, early treatment (e.g. crisis intervention - Caplan, 1964; Felix, 1967; Strickler, 1965; and Taplin, 1971) close to home, and could stay in the community with the help of drugs and social support, chronic mental disorder would disappear, there would no longer be a need for long-term hospitalization, and large mental hospitals would be closed.

Unfortunately nobody tested the theory (Smith and Hart, 1975).

The mental health movement experienced its initial impetus following World War II, but its growth accelerated markedly in the early 1960's as part of the widespread reoccurrence of concern for social and institutional reconstruction. Especially in the United States during the '60's a growth of the "community movement" took place, and has now also gotten under way here in Canada.

The core of the plan was:

> (1) to move the care and treatment of the mentally ill back into the community so as to avoid the needless disruption of normal patterns of living,
> (2) to make the full range of help that the community has to offer readily available to the person in trouble,
> (3) to increase the likelihood that trouble can be spotted and to have help provided early when it can do the most good, and
> (4) to strengthen the resources of the community for the prevention of mental disorder.
>
> (Smith and Hobbs, 1966)

The movement has been referred to by some as "Psychiatry's third revolution" (Bellak, 1964), and is obviously continuing throughout the seventies (Schulberg, 1972). Even the focus of individual treatment has begun to expand to include more of the patient's total system, his family, employment or school, neighborhood, and a variety of other institutional systems.

In spite of all the enthusiasm, and the bandwagon atmosphere surrounding the community mental health movement, it has, nevertheless, begun to be more closely examined and some criticism has developed (Dunham, 1967; Burrows, 1969). In addition to being seen as yet another poorly conceptualized and unresearched 'bandwagon', it has also been perceived as a potential mechanism of social control or political surveillance (Kenniston, 1968; Leifer, 1969). Two general concerns with the movement can be stated:

(1) an assumed relationship between the socio-environmental situation of an individual and mental illness where an alteration in the socio-environmental condition will lower the incidence of mental disorder, and

(2) a general concern for the inequalities in our service delivery mechanisms, where improvement in the delivery of mental health services will reach the poor, elderly, disabled, etc., who up until now have been denied adequate service. This it is hoped will decrease the prevalence of mental illness.

Evidence for the first concern has been minimal according to Morton Wagenfeld (1972), and perhaps at the present stage it will be more profitable to focus on the second. What is needed to deal with the program expressing the second concern is evaluation research. Are the new programs working effectively? If not, should they continue? Answers to these questions can be quite threatening but if they are not dealt with, community programs are vulnerable to any change in the political climate without themselves being able to influence decision-making. As J. S. Wholey (1970) pointed out:

> Evaluation is a decision-making tool. Its success or failure must also be measured, therefore, in terms of its impact on changing program policies and resource allocations.
>
> (p. 46)

It could also be suggested that unless evaluation is used in a decision-making capacity, there is no reason to do it at all.

The increasing dissatisfaction and difficulties with the large public mental hospitals, and the deleterious effect upon staff and patients of the large institutions with their custodial and repressive policies have been documented in several studies, e.g. Ullman and Gurel (1964). It is true that the mental hospital, rather than providing treatment services, has tended in the past to be a place, to which difficult patients could be moved from society. Decentralization of services has been welcomed as a way of providing total mental health care without removing the patient from the community, to which he must return. Yet, the release of chronic mental patients from the hospital to the community has been prompted more by political and economic considerations than any planned treatment strategy. Conditions for former mental patients in boarding homes and nursing homes are not much different from the back wards of large public hospitals. To date, few mental hospitals have had the funding, staff, support to adequately explore the possibilities of an optimal environment with an open social system built around the needs of patients as they themselves perceive them (Jones, 1975). So, community treatment and the planned complete phasing out of hospitals of the custodial, public type, has become official policy of federal, state, and direct or local government, especially in the United States, but increasingly in a similar manner in Canada, and with enthusiastic sanction from professionals and citizens' organizations.

A considerable literature demonstrates that psychotics can be treated in the community, can be discharged from hospital after very brief hospitalization, and can be maintained in the community as evidenced by lower rates of readmission. Studies (e.g. Wing, 1972; Pasamanick, 1967; and Hogarthy, 1973), have mostly been 'program effectiveness' studies which demonstrate that it is possible to accomplish the stated program or to implement a particular policy. Studies concerned with 'program benefits' - i.e. the cost and benefits attendant upon the implemented program are few. Other studies of the effects of community treatment on family, siblings and offspring, as well as the psychotic patient after discharge similarly remain scarce.

The study by Pasamanick (1967) lends itself to an examination of some of these issues, and answers to the saying of Lemkau and Pasamanick (1957) prefacing their discussion of the problem of mental health programs:

> Any fool can ask a question;
> the trick is to ask one that can be answered.

The study was a comparison of the effects of hospitalization and non-hospitalization, or generally speaking, home-treatment, on several groups of schizophrenics observed for six to thirty months. The authors conclusion was that the study did demonstrate the feasibility of caring for schizophrenics at home and that the methods and procedures used were effective in preventing hospitalization. Direct data for evaluating social cost and social policy are not provided in the study.

The study was conducted in Franklin County, Ohio, over a three-year period with patients diagnosed as schizophrenic, whose family members indicated a willingness to take the patient back home. The researchers randomly assigned 152 patients who came to the hospital for admission, and who met the above criteria, to three groups:

(a) a drug therapy group, which was sent back home
(b) a placebo therapy group, which was treated identically with the drug therapy group, and
(c) a hospital control group.

Those who were placed in home treatment were assigned a public health nurse who made weekly visits during the first three months. Extensive data on each patient were gathered through psychiatric evaluations, psychological tests, social histories, and nurses' reports. Some 77 per cent of the home on drugs group remained in the community throughout their participation in the project. However, only 34 per cent of the home on placebo group remained. Mean hospitalization period for the control group was 83 days, and this group failed more often at the termination of treatment. The authors documented the heroic efforts of the nurses in supporting families dealing with very difficult situations. It was reported that the most important improvement took place in the first six months of the patient's participation in his program. However, some of those kept at home showed considerable difficulty in functioning adequately in terms of symptomatology and instrumental role performance. Nevertheless, as in a similar study (Niskanen and Pikhanen, 1971), home care patients were functioning as well as or better than hospital controls. Since the families and communities of those patients who were hospitalized were relieved of the burden, whereas the families of home treated patients continued to experience difficulties, it can be concluded that there is considerable social cost involved in keeping the patient on home treatment at least during the initial, acute illness phase, with no clear-cut therapeutic advantage to the patient. A five year follow-up of Pasamanick's study (Davis et al., 1972) showed that an erosion of the initial differences had taken place, so that no differences in terms of rehospitalization or psycho-social functioning could be found between the groups. It was also found that soon after the project terminated, a large proportion of the home care patients failed.

Reduction in rehospitalization appears to arise from continuity of aftercare, especially if shorter initial hospitalization is to be undertaken, and its occurrence is not to be assumed (Mendel and Rapport, 1963; Clayhorn and Kinross-Wright, 1971). This recognition of the need for continuing care, particularly for the chronic patient has led to increased use of a variety of sheltered living situations, such as boarding homes (Swann, 1973); nursing homes, halfway houses, foster homes, foster communities (Keskimer et al., 1972), and landlord-supervised apartments (Chien and Cole, 1973).

Ellsworth et al. (1972) reported that the more 'productive' hospitals released 25 per cent of their annual census to special placements as those just mentioned, while the less 'productive' hospitals (as measured by turnover and decrease in long-term patients) released 8 per cent - growth in productivity correlating .61 with rate of special placement.

This may seem attractive in terms of cost and keeping the patient in the community, but there is evidence that the price may be too high in terms of the patient's suffering and well-being. Chronic patients finding themselves in special placements without trained personnel and without a treatment program show a high rate of adjustment regression. Unless adequate resources are allocated, special placement settings must be viewed as a particularly ingenious way of decentralizing and thus make invisible the neglect of archaic back wards. Economically also, it would seem that the move from the hospital to the community care will increase cost significantly. Various studies considering economic factors indicate the higher cost of community care (Smith and Hart, 1975; Crawford et al., 1971). One author states that the community care is provided at 67 per cent more cost than care via the public mental hospital system alone (Sheehan and Atkinson, 1974). The bargain obviously lies with the public funding authorities as the community will be funding the main part of the cost of community care. But then of course the question of cost is not the only factor or concept of importance when the move from hospital to community care is seen as a challenge and an opportunity for intervention by the community development agent, seeking to utilize this trend for the strengthening of a psychological sense of community.

Follow-up studies of psychotic patients returned to the community tend to reveal distressingly high percentages of marginal or poor adjustment, of unemployment, and a subsequent need for return to hospital. A recent survey on the situation of persons one year after discharge from psychiatric hospitalization, was produced by the Quebec division of the Canadian Mental Health Association (1974), and the findings support other studies, thus indicating the need for more intense evaluation in the community mental health field.

Yet another problem as a corollary to the move from hospital to community, and one which apparently has not been evaluated, is mentioned by Kahn (1969). He points out that thousands of schizophrenics and others, who could not bear children while in custodial settings, are now in the community with biological capability of reproduction. D. Rosenthal (1970) stated that the pattern of natural selection in man has changed markedly over time, and that this is apparently true for the mentally ill as for man in general. The increased reproduction of those previously in custodial settings increases their inputs into the potential gene pool. Given the striking research consensus on the presence of genetic as well as environmental factors in predisposition to and development of disorder in high risk populations, Rosenthal suggests that:

> future generations may include many more mentally ill persons, and those predisposed to mental illness, than exist today.
>
> (p. 11)

It is possible to dissect and criticize evaluation studies in mental health, but doing so may be doing an injustice to the main point of community mental health. Studies that are methodologically excellent and elegant, are most often devoid of practical value in this area. Community mental health is beset with urgencies that require action on the basis of plausible practicality, and the problem must be seen more as one of what to conclude on the basis of information obtained. All serious and thoughtful studies add in some measure to knowledge or lay the groundwork necessary for further pursuit of that knowledge.

In community mental health, evaluation must concern itself with such questions and innumerable others continuously vying with each other for priority. Obviously at present the elegant, well-polished experimental design would not allow the evaluator to meet the demands. At present perhaps the best one can do is to place problems in groups and utilize whatever experimental, or quasi-experimental, or even just rational design available to at least increase somewhat the amount of knowledge we possess.

Evaluation in community mental health should go beyond the measurement of specific goals which is the traditional approach. Thus, definition of evaluation must be expanded to include not only the analysis of effectiveness of the program in terms of goal performance, but also to include suggestions regarding the movement of the program in the future (planning). With that, evaluation should include what constraints to change exist in a particular program's system and which might inhibit modification. Data provided in the analysis of programs would become feedback and a first step into the decision-making system of the program. Though the use of a systems model, which also at one stage itself includes the goal model, may be more costly, there seems no doubt that this is the model, which should be primarily adopted by the community mental health movement. There is of course no guarantee that evaluation data will solve such problems, or any other problems, previously mentioned. However, without evaluation data, and the evaluation approach built into any consideration of mental health approach, modifying mental health programs and treatment approaches will be a process of groping about in total darkness.

As previously mentioned, the community mental health movement has been described as the third psychiatric revolution (Bellak, 1964). It has, however, been less of a revolution than was anticipated or desired. Generally, there has been a decrease in community action during the early 1970's, but the main reasons for the failure of the community mental health movement must be sought elsewhere. Thus the main stumbling block to advance in this area is, and has been, the orientation of mental health professionals to mental illness, and the treatment approaches accordingly accepted not only by psychiatrists and other professionals, but by the general public as well. The community mental health movement has been nothing more than psychiatry transplanted to an outpatient setting. It has become an extension of the old ideology of psychiatry (aberrant behavior as mental illness) to cover a larger part of society, though still ineffectively. It has focused on self-actualization for the wealthy patient, and rehabilitation simply for the poor. Returning to the community, the ex-patient has continued to be thought in need of quasi-treatment. This assumes that the patient has received direct treatment whilst in hospital - an assumption that can be made and taken for granted only at great cost and with dire consequences for both the patient and the community to which he returns.

The new community-based service has effectively helped to reduce the frequency of admissions to mental hospitals, but has failed adequately to perform "the social function of restoration of those whose needs are greatest" (Reiff, 1966). Continuing to see aberrant behavior as mental illness has forced treatment approaches to remain within the framework of medicine (psychiatry). Where suggestions for alternative views have been considered, a return to this old orientation and approach has at once been advocated

(Overall and Aronson, 1963; Garin et al., 1960). Thus it appears still to be true, that the more things change, the more they stay the same.

What is needed then is a new approach concentrating on the community and its culture, its definition of deviance, its stresses and supports. There must come a new ideology with a change from the concept of mental disorder as illness to the concept of mental disorder as social deviance (Scheff, 1966), and a true community approach to mental disorder or deviance must be prevention. A genuine community orientation requires a new understanding of mental disorders, where such may be considered personal, social, and ethical problems in living, not results of intrapsychic processes, but violations of social norms. Therefore, the ideology accepted and preferred by the public is of immense importance. For the community development agent, therefore, a consideration of such ideology and possible community approaches, which can be used in the attempt to facilitate the transition from custodial hospital care to a genuine community care, is of the utmost significance. In order to utilize this challenge for developing and strengthening a psychological sense of community, and for future preventive community development interventions, a closer look at the concept of mental illness may be of value to the community development agent. As stated by David Hawks (1975):

> That the real problem will be found to reside in our inadequate understanding of mental illness and the ainappropiateness of our present models and expectations is undoubtedly a more threatening view than that which suggests that all the problems result from the present-day organization and staffing of institutions and community facilities. It may, however, prove the more accurate diagnosis.
>
> (p. 284)

The Myth Of Mental Illness, And Models Of Madness

Treatment approaches to mental illness are necessarily determined by the ways in which the concept of mental illness is perceived, and by which shared reality, or ideology, underlying such perception happens to be the dominant one, or the most readily accepted one in the community at one time. This too, as was shown in the preceding section, will determine the preferred modes of referral as evidenced by the way in which members of the community actually deal with occurrences of 'mental disorder' amongst themselves. Therefore, of special importance for the community development agent with regard to future preventive interventions is a clear idea as to what mental illness is, how it is perceived by members of the community, and how members of the community refer persons said to be suffering from such mental disorder. Again, this is important in that the rejection of long-term institutional care of mental disorder, and the acceptance of community care rest on various assumptions (e.g. Hawks, 1975; Murphy, 1975). There is a trend away from somatic models toward explanations, or models, emphasizing the role of socio-psychological factors (Baker and Schulberg, 1967; Geller, 1975). If the community is in fact to be therapeutic, and itself to be seen as a source of mental health "ensuring the self-development, safety, and fulfillment of all its citizens" (Klein, 1968), a move toward community care can be seen as desirable. If determination of insanity is a social judgment, and not a scientific issue, this problem becomes of immediate and overwhelming importance in any type of community development work. In order to facilitate a move from treatment in institutional, traditional mental hospitals, which in fact destroy the true psychological sense and meaning of community, to treatment and prevention within the community, it is necessary to seek knowledge of the preferred model of mental illness within the community. If the preferred model is less compatible with a move from hospital to community, there is a need for people in the community to change their model of mental illness to one more compatible with the ideas underlying the move to transfer the "mentally ill" back into the community. To facilitate such a move and change is community development, and of urgency to anyone interested in revitalizing and strengthening the social experience known by the shorthand term: community.

What is "Mental Illness"?

Once upon a time ... as most good fairy tales begin, man could be possessed by demons and evil spirits, or he could be under witches' spells, and the result, "mental illness", could be understood fairly easily even by the layman. Later, as this conceptualization became less readily accepted, many and pejorative names were invented to characterize and describe the behavior of the unfortunate ones, the insane, crazy, senseless, mad, and lunatic fellow community members. Then, as such behavior since the nineteenth century has become defined as a medical problem with a somatic causation, it has become increasingly more mysterious to the layman, and increasingly more difficult to understand the true nature of "mental illness". Instead of being used as a convenient label for observed regularities of behavior, "mental illness" has been made into an actual disease. The understanding of such disease has traditionally become the domain of the trained medical personel solely. But even the professional has difficulty with the definitional process. Perhaps a definition of mental health would be easier? Several attempts have been made, yet a clear picture has not been presented, nor has very much of a convincing agreement been achieved. Thus, for example:

> (Mental health is) the full and free expression of all our native and acquired potentialities, in harmony with one another by being directed towards a common end or aim of the personality as a whole.
>
> (Hadfield, 1950, p. 14)

> Mental health as the committee understands it is influenced by both biological and social factors. It is not a static condition but subject to variations and fluctuations of degree; the committee's conception implies the capacity in an individual to form harmonious relations with others, and to participate in, or contribute constructively to, changes in his social and physical environment. It implies also his ability to achieve a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives --- harmonious in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others. It implies in addition an individual whose personality has developed in a way which enables his potentially conflicting instinctive drives to find harmonious expression in the full realization of his potentialities.
>
> (W H O, 1951, p. 4)

> 'Mental health', in a very broad sense, might be defined as the goal of our attempts to achieve for each individual the development of his potential capacities so that he will be respected by himself and by the groups of which he is a member.
>
> (Zimmerman, 1955, p. 215)

> For the first component of a healthy personality I nominate a sense of basic trust, which I think is an attitude towards oneself and the World derived from the experience of the first year of life. By 'trust' I mean what is commonly implied in reasonable trustfulness as far as others are concerned and a simple sense of trustworthiness as far as oneself is concerned.
>
> (Erikson, 1956, p. 117)

A few recurring factors in these definitions seem to suggest that mental health involves happiness, energy with full use of a person's capacities together with freedom from conflict with oneself, and a harmonious adjustment to the environment. However, it can be seen that most of the definitions rest on a tacit assumption of the correctness of the Protestant-Ethics system, and on definite value judgments, although at a cursory first glance they may appear to be objective, and scientific expressions of the concept of mental health. They all suggest that mental health infers an adjustment, but adjustment here must mean, and does, adjustment to a particular culture or to a particular set of institutions. In this sense then, mental health would mean simply the ability to come to terms with that culture, or with those institutions. Here obviously one encounters difficulty - a difficulty, that mental health must be seen in a cultural perspective. What may be accepted as mental health in one culture may not necessarily be considered as mental health in some other culture. It could for example be asked whether the Hutterite sect, whose members live in self-contained communities in Canada and the Western United States, under a system of communism in its classical, non-political sense, can be regarded as a healthy community. Eaton and Weil (1967) state:

> There is considerable objective evidence that the great majority of Hutterites have a high level of psychological adjustment. ... Mental health involves value judgments and depend on what people want from life. ... Their culture (the Hutterites') is therapeutic only for conformists.
>
> (p. 100)

In this case it can be easily seen that the concept of mental health is not a scientific, but a social or value judgment. In an authoritarian culture, like the traditional Japanese, to be too much of a free, independent and adaptable individual may be considered as an obvious lack of mental health. On the other hand, not to be free, an independent and adaptable individual, encouraging the ideal of free enterprise, would in North America be considered an obvious defect in the person's mental health. Various attempts at clarifying the concept of mental illness from a cultural perspective have been made.

Boas (1919) did much to point out that cultures vary widely with regard to categories of social structure and function, and that mental illness, therefore, would naturally be determined by the

special culture, in which it occurred. The disturbance can be understood only in terms of the cultural and social pattern within which it occurs, but it appears that the special form or style, it takes, is a secondary function of abnormality. Thus R. Benedict (1934) appeared to be seeking for an absolute and universal criterion of 'abnormality' in spite of cultural differences. This, however, especially was criticized by Foley (1935), who from studies of ethnological material, inferred that abnormality is a relative concept. Support for this can be found in Czaplicka (1914), who presented descriptions of 'arctic hysteria' as an example of a special cultural style of madness, and by Fortune (1932), who mentions the unnatural fear and suspicion of the Doubars. Van Loon (1926) in an analysis of 'latah', which appears similar to 'arctic hysteria' and to 'amok', disagrees with Fortune's suggestion of culture specificity, and is more in agreement with the suggestion by McDougall (1926) and Seligman (1929), that temperamental differences in ability to adapt oneself to varying environments would account for the apparently culture specific forms of mental disorder.
Mead (1928, 1930) suggests that culture does determine abnormality via the number of possible conflicts it can present to its individuals. Thus she indicates how when Christianity was introduced to Samoa, a different set of standards brought a wider choice in abnormal behaviors to the island. This approach is supported by Skaggs (1933) stating that he sees abnormality as a qualitative, and not a quantitative concept. Lack of integration and balance of the total

personality then seems a most logival definition. Thus as suggested by Wegrocki (1939): "It is not the mechanism that is abnormal, it is its function which determines its abnormality" (p. 36).

The occurrence of all the major forms of mental disorders in primitive societies has been confirmed by several authors (e.g. Field, 1960; Toker, 1966; and Elsarrag, 1968). Though there may be cross-cultural differences in the manifestation of these disorders, it may be thought that similar processes underlie them all. To help finding answers to this, Zubin (1966), and Zubin and Kietsman (1966), postulated an experimental culture-fair approach, by which it was expected that similar response patterns (for example psychophysiological) could be found across the different cultures. As human beings react to inevitable problems of life via similar physical systems, it is not surprising to find that characteristic human forms of maladaptive reactions to intolerable stress situations are expressed across different cultures through the same major varieties of mental disorders. An interesting line of possible research can be found in the suggestion that psychiatric disorder in some cultures described as shame-oriented are likely to take the form of antisocial, aggressive acting out behavior that is disturbing to the community more so than to the individual, whereas in a guilt-oriented culture, such as the Hutterite, there is a higher occurrence of depressive reactions. This resembles the terminology of other-directed (shame), and inner-directed (guilt) as used by

Reisman (1950), and suggests a further potential usefulness of Julian Rotter's (1966) interesting Internal-External control concept.

No real agreement on a definition of mental health has been possible. It is not surprising, that at a meeting of some of the leading American psychiatrists, doctors, sociologists, and anthropologists, all "researchers in the field of mental health", the question: What is mental health?, was received in silence (Menninger, 1951). Too often as well, a search for a description of mental health changes into a concern with the normality-abnormality question. However, one can speculate whether a more active response would have been evoked had the question been: What is mental illness?

Models of Madness

A review of research criteria for mental illness was made by W. A. Scott (1958). His conclusion that conceptual and methodological difficulties in the various definitions, "suggest certain basic incompatibilities among the various approaches to conceptualization of mental illness" (p. 43), is not unexpected. He finds current definitions unworkable and at variance with each other, after having examined definitions grouped into six categories, viz. exposure to psychiatric treatment, social maladjustment, psychiatric diagnosis, subjective unhappiness, objective psychological symptoms, and failure of positive adaptation. Here again, the obvious is that there is no agreement amongst the professionals in the mental health area as to what constitutes mental illness.

As was previously indicated, most aberrant behavior was, up until the eighteenth century, thought to be the result of some form of supernatural invasion and intervention. Though introduced by Hippocrates of Greece about 400 BC, the concept of aberrant behavior as a result of some underlying brain- or biochemical defect, did not gain widespread acceptance until the nineteenth century. It was then that advances in the science of physical medicine suggested the existence of "diseases" of the mind, and the two main ideologies, the religious and the medical approach, originally fused into one and following parallel courses, like unseparated Siamese twins, now became two independent approaches. Gradually the religious approach has withered and remains but as an almost totally parched riverbed.

According to Foucalt (1965), and Szasz (1970) the medical approach had reached such dominance that already by the end of the eighteenth century a medical certificate had become obligatory for the confinement of the "mentally ill". Then in the nineteenth century major advances were seen in the fields of microbiology and surgery, and it was believed that bacteria would be found as the cause for all that was wrong with man. Neurophysiology and neurology made significant findings, and aberrant behavior become more firmly established as a disease in the brain, mental disease.

Treatment approaches were atrocious. As an example can be mentioned the spinning chair of Rush, the founder of American psychiatry. This was used to counteract congested blood in the brain, thought responsible for the mental illness. Thus:

> In my intended publication upon madness, I hope to satisfy you that the disease is arterial, and that without morbid action in the blood vessels of the brain no form of the disease can exist.
>
> (Galdston, 1967, p. 105)

Then in the early years of the twentieth century, Emil Kraepelin (1855 - 1926) at last unequivocally established the medical model by naming and categorizing aberrant behavior as "mental disease". As with Rumpelstiltskin of the fairy tales, it now became definite that if you can name it, then you can understand it. Now a classification system existed so that if anyone was in doubt about an unusual behavior, all that was needed was to find the correct code number, and doubt about the behavior being part of a "mental illness" need no longer exist. Not only did Kraepelin differentiate between manic-depressive psychoses and dementia praecox, but he went one step further and placed the latter in the category:- incurables. This has ever since been reflected in a pessimistic and predetermined view with respect to therapeutic approaches for the unfortunate ones placed in this group.

The medical model of mental illness, which has been clearly described by Ullmann and Krasner (1965), even today is the dominant model, and occupies much of the thinking of professionals. John S. Strauss (1973) discusses the diagnostic models within the medical model, which apparently is accepted basically as the correct model. He mentions the existence of a typological model which is the most popular though not based on clinical validity or the nature of psychiatric variables (sic). He mentions a mixed model, but admits that it is at present too complex for general use. It has the advantage though, that it meets "the scientific need and human desire to categorize". Finally he mentions the dimensional model, which has never been widely accepted, perhaps since it does not categorize? As Strauss (1973) suggests:

> Dimensional models by their failure to define discrete types also fail to meet what seems to be an important psychological need to categorize with the feeling of mastery and knowledge that accompanies the bestowing of a name.
>
> (p. 448)

Indeed, Rumpelstiltskin can happily continue his dance in the forest of ignorance. The author's conclusion nevertheless is that because of increasing evidence supporting the dimensional model, "it will be important to attempt more vigorously to develop a dimensional system that is simple" (p. 449). A plurality of typological diagnostic models exists. A 70 page list of the more popular ones can be found in the appendix to Menninger's (1963), The Vital Balance, and 39 different systems in use in present-day psychiatry have been listed by Stengel (1960). Mixed models most widely used have been described by Stierlin (1967), Conrad (1959), and by Klein (1967), who gives both typology and dimensionality equal importance. Dimensional models have been suggested for example by Menninger (1958), Eysenck (1970), and by Kendell (1968), who utilized the flexibility of dimensions without sacrificing the ability to categorize - the persistence of Rumpelstiltskin indeed. Thus a fairly standardized nomenclature for diagnostic categories of "mental illness" syndromes has evolved within the medical model, and summary discussions of this can be found in Clausen (1966), and inUllmann and Krasner (1969).

Adams (1964), Ullmann (1967), and Ullmann and Krasner (1969) point out how the major part of the current medical model essentially is a psychoanalytical model based on Freud's ideas, even though Freud himself realized that something was wrong with his medical model:

> The internal development of psychoanalysis is everywhere proceeding contrary to my intentions away from lay analysis and becoming pure medical specialty, and I regard this as fateful for the future of analysis.
>
> (Jones, 1955, III, p. 297)

Critique of the medical model has come mainly from sociologists and behavioral psychologists. Thus it has been found "scientifically inadequate", and "therapeutically ineffective", and ignoring important variables in the social milieu (Scheff, 1966; Taber et al., 1969; and Milton and Wahler, 1969). The medical model has been presented with an inadequate conception of relationship between individual and societ (Dunham, 1965; Clausen, 1966; and Weinberg, 1967), and it has been suggested that the impact of the model on individuals and community has had undesirable social consequences. Furthermore, only for a very small number of cases have neurological lesions been found (Ullmann and Krasner, 1969, pp. 130 - 139), and the search for genetic, anatomical and chemical causes, especially for schizophrenia, has failed (Mosher et al., 1970). There also can be no doubt that other social factors besides the behavior itself affect the informal and formal processes whereby persons are judged to have a mental pathology (Mechanic, 1967; Scheff, 1967; andUllmann and Krasner, 1969). "mental illness" has, by the use of the medical model, been made into an actual disease, a development which has been strongly rejected by many, especially by Szasz (1961, 1967), who points out how far this reification has gone by calling "mental illness" - a myth. Others too (Adams, 1969; and Zinberg, 1970) insist that there is no such thing as "mental illness".

Various attempts to assess the validity of the medical model have been made. Thus for example, the medical model has been found less effective than learning-based behavior modification procedures for "treatment" of aberrant behaviors, or so-called mental illness, and when evidence on the symptom substitution hypothesis has been examined, the evidence has been found negative (Eysenck, 1960; Wolpe et al., 1964; Ullmann and Krasner, 1965; and Bandura, 1969). Thus it has not been possible to find any objective critera of illness. Jackson (1969) points out how numerous studies have shown the low reliability and limited predictive value of systems for classifying mental diseases, and Jahoda (1958) dismisses the medical approach to normality and mental disease in just five pages. The mental illness label appears to be a leftover, wastebasket category, and Menninger (1969) dismisses the most recent classification effort as "sheer verbal Mickey Mouse". To say that someone is mentally ill, therefore, is not to be in a position to apply scientific measurement against objective criteria or standards of mental health, but to make a social, legal, or moral judgment about that person's undesirability. As pointed out by Szasz (1961), and by Goffmann (1961), the label _sick_ merely replaces other labels such as bad or crazy. Yet the medical model still dominates, and is often uncritically accepted (e.g. Gove, 1970). There have been attempts at responding to the critique (e.g. Ausubel, 1961), though they have not been convincing.

What is called mental illness is typically what Szasz (1967) calls: "problems in living", and "communications expressing unacceptable ideas", and what Lemert (1967) calls: a "disorder in communication between the individual and society". Such different names or statements could all be subsumed under behavior disorders which is free of the illness assumptions (Milton and Wahler, 1969; Rachman and Teasdale, 1970). What is called mental illness then, could be characterized more simply and more functionally by one or more of the following: situational inappropriateness, behavioral deficit, presumed irrational motivation, inappropriateness to one's age, sex, and other attributes, based on emotional disturbance (Bandura, 1969, pp. 3 - 9), or lack of behavioral and role skills, inadequately reinforced behavior (Ullmann and Krasner, 1969, pp. 92 - 105). To view "mental illness" under such perspective would strongly support the suggested move of the "mentally ill" from treatment in custodial institutions to care and increasing participation in the community.

Though the most dominant, the medical model is not the only model in use at present. A rather large number of different approaches to an understanding of mental illness have been proposed, and at present this appears to be a time much like a transition period from one dominant ideology to another. Thus in the beginning of the twentieth century the Mental Hygiene movement attempted to suggest that insanity, or mental illness, is not deviant, but just like any other illness. This attempt was carried forward in the community mental health movement, but appears not to have been widely accepted by the general public. To the majority of community members to be mentally ill is to be deviant and stigmatized (Nunnally, 1967; Scheff, 1966). Many theories, or models, such as biochemical, genetic, religious, sociological, psychoanalytical, cross-cultural, interactional, legal and moral models, have been put forward in order to explain mental disorder. Siegler and Osmond (1966) suggest that all such theories can be grouped into six groups, or models, viz. medical, moral, psychoanalytical, family interaction, conspirational, and social. In order to clarify differences and similarities between these models, the authors compare them on a series of dimensions, which though derived from the medical model, nevertheless, throw some light on the reasonableness of the various models.

The way in which mental illness is perceived by members of the community is important because the acceptance of different models or ideologies suggests varying treatment approaches, which can be seen as being given expression through the preferred modes of referral of the general public. For the community development agent a knowledge of the ideology prevalent in the community is important as the kinds of intervention attempted will depend on the kinds of assumptions the community member makes about mental illness. In order to facilitate the move from custodial treatment approaches to a community care approach and to utilize this event as an opportunity to strengthen and develop a psychological sense of community, the community development agent needs to know and to assess the ideology subscribed to generally by members of the community.

Rokeach (1968) defines an ideology as:

> an organization of beliefs and attitudes ... that is more or less institutionalized or shared with others, deriving from external authority.
>
> (pp. 123 - 124)

This is by no means the only meaning in which the term, "ideology", is and has been used, but it conveys the meaning of ideology as described previously, and as it here refers to the varying perspectives under which mental illness and consequent treatment approaches are seen. Kurt Lenk (1961) gives a useful overview of the changing meanings of the term in the history of both Marxism (though its origins must be sought far earlier), and of the sociology of knowledge. However, what is here meant by ideology is a more or less systematic interpretation of issues of importance to the community, and regarded by those who adhere to it, as an absolute truth. By accepting an ideology a feeling of shared "knowledge" generates a feeling of solidarity and power. The ideology as a means of bringing order into one's perception of reality becomes in actual fact patterns of ideas serving as weapons for social interest. Because of its influence on human thinking, the ideology has power to change the social context or to withstand attempts at social change. In dealing with a transition of the mentally ill from institutional care to community care and a more full participation in community life, the community development agent may find it necessary to aid in changing an accepted ideology concerning mental illness that favors institutionalization, to one that is more compatible with accepting the "mentally ill" into the community. Wolfensberger (1972) suggests there are "probably only two ways to improve the quality of our ideologies" (p. 9). One way is to root out ideologies held unconsciously and presumably increase awareness of ideologies embraced. Secondly, he suggests, that:

> Just about the worst that can happen is that we do as badly as in the past, while the best that can happen is a breakthrough to a new age. ... that we embrace a new ideology, tried or untried.
>
> (p. 9)

The hope for just such a breakthrough was given expression recently in the emergence of the community mental health approach as an ideology in addition to and in opposition or contrast to previous ideologies and models.

There are many definitions of this new movement within mental health. Thus for example Goldston (1955) in addition to quoting several of these, suggests that community mental health most frequently refers to the administration and provision of a variety of mental health services. Thus in addition to the traditional diagnostic and treatment services, there is an effort to provide service through day- and night hospitals, through foster home care, and through the development of mental health information programs for the general public. Further to the base core of the plan for community mental health as stated by Smith and Hobbs (1966), previously mentioned, Murray Levine (1970) has outlined and discussed the postulates of community mental health practice. Briefly, the five postulates are:

> Postulate 1: A problem arises in a setting or in a situation; some factor in the situation in which the problem manifests itself causes, triggers, exacerbates, or maintains the problem.
>
> Postulate 2: A problem arises in a situation because of some element in the social setting that blocks effective problem solving behavior on the part of those charged with carrying out the functions and achieving the goals of the setting.
>
> Postulate 3: Help to be effective, has to be located strategically to the manifestation of the problem, preferably in the very situation in which the problem manifests itself.
>
> Postulate 4: The goals or the value of the helping agent or the helping service must be consistent with the goals or the values of the setting in which the problem is manifested.
>
> Postulate 5: The form of help should have potential for being established on a systematic basis using the natural resources of the setting or through introducing resources that can become institutionalized as part of the setting.
>
> (pp. 72 - 75)

The basic effect of the community mental health approach has been to seek to provide such services at the local community level in conjunction with other types of community services. Thus there has been attempts at improving the quality and effectiveness of local mental health services. Yet, it appears that the only real innovation is that a broader outlook has been taken concerning etiology and treatment.

Services by the mental health centers, which were set up, were to provide their program to a defined population base, the catchment area. The principle behind this was that it would provide more accesible services and allow local programs to be shaped to meet community needs. It also would provide a vehicle for community participation in the decision-making, a principle basic to community development projects as well. However, catchmenting has been a source of conflict, and it has been objected that it was too rigid a concept. Initially it was thought to provide services for a limited area with between 50,000 and 200,000 inhabitants. Discussion on the boundary of such an area has not been settled, though most in actual practice are aimed at somewhere between 10,000 and 50,000 persons. More empirical evidence is needed to determine the appropriate bases on which to establish boundaries. As Becker and Schulberg (1976) point out, it was intended that local community services and state-hospital programs should be linked, though this connection has rarely been seen to exist. Distance between the catchment area and the 'back-up' units in the larger institutions also has made it difficult for joint programs to be properly worked out and maintained. The difference in ideology between staff of the community mental health centers and staff at the custodial institutions also has been effective in disrupting cooperative efforts. Thus, in actual practice the establishment of catchment areas has not provided for advance in the effectiveness of treatment approaches within community mental health. It has been difficult to find evidence that supports the assumption upon which the catchment area was developed. It has been said that this practice will lead to a rational system of coordinated services and to consequent improvement in the mental health care delivery programs. There has, however, been only a very few studies attempting to corroborate this. One study making the effort was done by the Connecticut mental health center in collaboration with Yale university (Tischler et al., 1972; and Goldblatt et al, 1973). This quasi-experimental situation indicated that the practice did increase utilization of local services, but that the impact on the state hospitalization rate is complex. Also indicated was a better crisis intervention, fewer dropouts from treatment, and better consumer satisfaction. One can only lament that other empirical studies are not available.

There can be no doubt that such catchment areas are too large, and still tend to provide means of removing the "mentally ill" from the community to which he/she rightfully belongs. In order truly to provide community care, the approach must be one of seeking to integrate fully the mentally ill into the community, and to develop within the community itself, as part of the everyday activities within the community, means and methods for preventing the occurrence of mental illness, however defined. At best the community mental health effort as it presents at present can be seen as an attempt at developing a public health approach in psychiatry.

Prevention, of course, has been a main tenet of the community mental health approach, and by prevention is here meant the whole of Gerald Caplan's (1964) hierarchy: primary, secondary, and tertiary prevention. However, concern with primary prevention has been more in rhetoric than in delivery. Up until now, the community mental health effort has been directed overwhelmingly towards secondary prevention. More attention to primary prevention is needed, and as suggested by Jacquelyn E. Murray (1975):

> It consists of identifying the communities and families that are liable to have high rates of deviance, and of providing services to these communities and families aiming at striking a balance between stresses and supports.
>
> (p. 2036)

Emphasis has also been placed on mental health consultation, but as an interaction process or interpersonal relationship between two professional workers only (Bindman, 1959; Caplan, 1964). This too, if it is ever to be effective in a community care approach must be extended to cover a much larger network of relationships.

Generally speaking the community mental health ideology has not provided that which was promised. Nevertheless, the acceptance of this ideology must be seen as a step toward a more valuable approach to the question of what to do with, and how to deal with those who at present are considered to be "mentally ill". It is important for any community development intervention in order to be successful, to have been conceived and planned on the basis of a knowledge of the predominant ideology among the community members.

It is, therefore, surprising to find from a brief review of the literature, that though some work has been done with respect to mental health personnel, it appears that attempts to study the underlying ideology of attitudes toward mental illness, which largely determines community approaches to the problem of mental illness, and which has great importance for community development, have been left aside in studies with the general public.

A series of studies by Gilbert and Levinson (1962, 1964, 1965) examined the nature of the ideological position of humanism versus custodialism, and the Custodial Mental Illness Ideology Scale (CMI) was constructed to probe these questions and positions. It was applied to personnel in hospitals, and the authors found the ideological positions related to the concept of authoritarianism and to measures on the California F scale. The use of the CMI was not extended to the general public in the community.

Similarly Cohen and Stuening (1962) developed a multidimensional scale: Opinions about Mental Illness (OMI), and again this scale was applied in studies of hospital personnel, with the ideological model moving only slightly away from a medical model. As was the case with the CMI, the use of the OMI scale was not extended to the public.

Ehrlin and Sabshin (1964) studied three rather independent ideological orientations: the psychotherapeutic, the somatotherapeutic, and the sociotherapeutic. The study concerned itself with psychiatrists, but again no attempt was made to extend to the general public.

Neither of these scales have been able to differentiatiate clearly between the followers of the kind of ideologies based upon or accepting some type of medical model, and followers of an ideology differing essentially from such a model.

A Community Mental Health Ideology scale (CMHI) was then developed by Baker and Schulberg (1967) which was used to identify the same three ideologies as that of Ehrlich and Sabshin (1964). The CMHI has shown itself to be able better to differentiate between adherents to a custodialism ideology, and adherents to a more liberal community approach ideology. Even then, though the authors suggest further research with the scale, their suggestion is limited to the statement that:

> Data for nurses, social workers, and other mental health specialist populations are still needed.
>
> (p. 225) .

Again, as far as a review of the literature suggests, the use of the scale was not extended to the general public. For the community development agent, concerned with a transitional move of the mentally ill from custodial institutions to community care, it is exactly the ideological stand of the community members that is crucial to know. Thus, since the scale apparently has never before been used with members of the community in general, it was proposed in this study to extend the use of the scale to the general public in the community.

This extended use of the CMHI scale could suggest the closeness of the community to an acceptance of the ideology underlying the community mental health approach, and more importantly, the community development approach by extension. Thus not only is an indication of level of community preparedness for the previously mentioned transition of the mentally ill expected to emerge, but also the preparedness of the community fof community development preventive interventions in the area of mental health.

Since community development is primary prevention when at its best, such a search in relation to mental illness is of immense importance for future community development work in the mental health area, and in general. A need for preventive education in the schools, in adult learning settings, in and through neighborhood service centers can be anticipated. For the community development agent this basically is his area of concern, and his skill in the process will manifest itself to the extent that he adheres to his ideology and the principles of community development.

However, with little or no change in attitudes toward the "mentally ill", a return to the community by patients has in many ways extended the philosophy of custodialism into the community rather than ending it at the gates of the large mental hospitals (Murphy, 1971; Lamb and Goertzel, 1972). One serious problem of reintegration is that of social rejection of the mentally ill (Phillips, 1963; Aviram, 1973), who are likely to possess multiple negative social attributes in addition to their mental disorder, and which further complicates their return to the community.

8

Former patients are not welcomed back into the community with open arms, and may end up as readmissions to the large mental hospital, or living isolated lives in slum areas of the community (Ellsworth et al., 1968; Quebec Div. Canadian Mental Health Association, 1974; Denner and Halprin, 1975). Thus 'residence in the community' can be as disabling, frightening, dehumanizing, and isolating, as living in the back-wards (Jones, 1975). Such a situation is partly due to the fact that the general attitude toward mental disorder, held by the public, is negative. Attitude toward mental disorder will significantly influence the behavior of the public as referral source, with consequences for the mentally ill, as well as for the community as a whole. It is, therefore, important to investigate such attitudes as an important part of the community development intervention effort, and a necessary step in planning for immediate and future efforts by the community development agent.

Acceptance In The Community Of The "Mentally Ill"

In conjunction with the rise of Social Psychiatry, Community Psychology, and the Community Mental Health movement, a great interest in attitudes and opinions about mental illness developed (e.g. Cumming and Cumming, 1957; Gilbert and Levinson, 1957; Nunnally, 1961; Holtzberg and Gewirtz, 1963; Mangum and Mitchell, 1973; Brown, 1974; and others). Over the past twenty years a sizeable literature and body of research has arisen concerning itself with delineation of attitudes toward mental illness and the mentally ill as held by various groups, notably mental health personnel, but also patients themselves, their families, and in some studies, the general public. Thus for example Cohen and Struening (1962) in what is stated to be only a first step in a larger investigation sought to identify salient dimensions underlying opinions among hospital personnel and professionals about severe mental illness, and relate such measures to demographic characteristics of the respondents. The outcome of their efforts is the OMI scale with the capacity to some extent to differentiate between an authoritarian custodial approach, and a mental hygiene approach. The authors suggest that their scale is an improvement on the Gilbert-Levinson (1965) CMI scale in that the OMI scale appears to single out also a benevolence factor, thought to be an important quality in psychiatric aides and nurses. In the same year, Lemkau and Crocetti (1962) in a study of the population in the city of Baltimore, found that contrary to the findings from earlier studies, public feeling about the mentally ill was "characterized by fear, anxiety, stigmatization, rejection, and misinformation" (p. 692), the public appeared to understand and have a tolerance for the mentally ill. They did not find evidence that the public has a tendency to deny mental illness, but when mental illness was identified, there was a definite "pervasive defeatism", a certain pessimism regarding the likelyhood of the mentally ill being "cured". Yet the authors suggest that this does not indicate pessimism or defeatism in the face of identified mental illness - a somewhat incomprehensible and ambiguous position to assume. The study is said to have shown that the public do not wish to isolate and reject the mentally ill. The authors, therefore, conclude that attitudes toward the mentally ill are changing and that the population is more ready to provide home care for psychiatric patients than is generally suggested by other studies.

Ellsworth (1965) was interested in finding whether a person's endorsement of an attitude (custodialism, humanism, etc.) would determine that person's behavior in relating to psychiatric patients. Using staff in a mental hospital, the author found support for defining an attitude:

> as an underlying disposition which enters into the determination of a variety of behaviors toward an object or a class of objects, including statements of beliefs and feelings about the object and approach-avoidance acting with respect to it.
>
> (Cook and Selltiz, 1964; p. 36),

but also that a congruence between endorsed attitude and behavior depends on the situational demands of a particular setting to a large extent. Then in an article for Social Psychiatry, von Baeyer (1966) points out how a modern social psychiatry must deal with our own personal attitudes to the mentally ill, if it is to be effective. He presents a community mental health approach in general, and a family oriented emphasis in particular toward the acceptance of responsibility for the mentally ill, pointing out how the community is partly responsible for the occurrence of the problem of mental illness. Von Baeyer indicates that approximately one per cent of the population fall into the category of those suffering from schizophrenia, who account for some 60 - 80 per cent of the inhabitants of psychiatric institutions. At the same time, he points out how in countries, where a social psychiatric approach has become more accepted, the number of hospitalized schizophrenics has reduced, thus making the financial cost to society less. Thus for example in Denmark, the total number of hospitalized schizophrenics reduced over the years, 1957 to 1962, by 18 per cent. He suggests that the traditional, medical approach, has built a barrier between the members of the community, and the strange, "incomprehensible" mentally ill, thus disrupting a feeling of solidarity with the mentally ill. He suggests two causes for this lack of solidarity, which must be overcome: one is the lack of reciprocity encountered in dealings with the mentally ill. This will call for an initial unselfishness of the community members to develop. Secondly there is a barrier to a solidarity feeling in our limited capacity for understanding. Only with people that we understand do we feel ourselves at ease. This suggests a need for education and consultation as an intervention, calling for a "concerted effort on the part of the community to undertake, in a discriminating and progressively gradual way, its responsibilities toward the mentally ill" (p. 2). "The crucial role played by the general public in determining who shall receive care" (p. 152) was correctly emphasized by Fletcher (1969). It is the members of the community who decide which kind of behavior is to be considered deviant or as that of the "mentally ill", and the study of the preferred modes of referral of the general public is extremely important for any type of intervention and community development effort. The present study sought to examine the possibility of a correlation existing between the accepted or preferred model of mental illness, and the community member's preferred modes of referral, seeking a foundation for planning and for the use of community development intervention stategies in an effort to aid a reintegration of the "mentally ill", and strengthening a growing psychological sense of community.

The following year, Sarbin and Mancuso (1970), in an interesting review of studies on attitudes of the public toward mental illness, find evidence to support the validity of three major propositions, viz.:

> (a) The ordinary citizen is willing to tolerate and to accommodate to extensive behavior deviations;
>
> (b) the public is hesitant about using the mental illness label for those behavior deviations and unusual solutions to life's problems which psychiatrically oriented diagnosers would unhesitatingly label mental illness;
>
> (c) if the semantic tag, mental illness, is attached to a particular behavior, the public will tend to reject and to advocate isolation of the person whose behaviors are thus labeled.

The authors looked for the consequences of continued attempts to persuade the public to employ the illness metaphor when describing improprieties in behavior. Their conclusions were that the public is rejecting of people categorized as mentally ill, and that to a large extent the public does not find it necessary to categorize deviant conduct as mental illness. Nevertheless, the public feels that if labeled mentally ill, the person should be moved out of the community. The efforts of the community mental health professionals thus appear to have failed. Again, the attitude held by various staff groups at the Berlin Free University Clinic was examined by de Carozzo (1971), using the CMI scale. She found significant differences depending on occupational and educational levels, as well as corroboration of the findings by Lemkau and Crocetti (1962), that groups with a lack of information on mental illness tend not to have positive attitudes to the mentally ill (p. 38).

An excellent review of studies of attitudes about mental illness, mental hospitals, and mental patients, together with a brief outline of historical trends in such attitudes can be found in Rabkin (1972). She discusses the CMI scale, the OMI scale, and Baker and Schulberg's (1967) community mental health ideology scale (CMHI).

Several studies testify to the common, negative and rejecting attitudes that most members of the public hold toward mental illness, and the mentally ill (Cumming and Cumming, 1957; Ramsey and Seipp, 1948 [a,b,]; Hollingshead and Redlich, 1958; Nunnally, 1961; and Susser and Watson, 1962). Thus Cumming and Cumming (1957) in their study of a small Canadian town found so much of a negative attitude that they had to abandon their proposed program of mental health education. Susser and Watson (1962), examining this study, point out that to suggest, as did the Cummings, that normal and abnormal behavior fall within a single contimuum, and thus that anyone can become insane under certain circumstances, would be opposed to a generally accepted value system extending beyond a concern with attitude toward mental illness. Thus it was found not feasible to change such attitudes. In 1947, adults in New Jersey in a simple survey were found more optimistic about the possibility of recovery and not too worried about association with the mentally ill (Ramsey and Seipp, 1948 [a,b.]). Nevertheless, the much more sophisticated study by Nunnally (1961) found that:

> as is commonly suspected, the mentally ill are regarded with fear, distrust and dislike by the general public.
>
> (Nunnally, 1961; p. 46)

As far as demographic variables were concerned, Nunnally did not find any relationship to the stigma associated with mental illness, but the mentally ill ... "are considered, unselectively as being all things bad" (p. 233). Freeman and Kassebaum (1960) in addition found that knowledge of facts, and of technical, psychiatric vocabulary did not appear to influence the negative attitude of the public. In contrast to these studies, Hollingshead and Redlich (1958) found that upper-class members of the public were more accepting of mental patients. It also appeared that disturbed behavior which is more socially visible influences attitudes toward the negative position, even in psychiatrists (Manus, Hunt, Brawern, and Kercher, 1965). Phillips (1963, 1964) in a study of white, married women found that they also reacted more negatively toward visible, disruptive behavior. In a replication study, Yamamoto and Disney (1967) using student teachers found similar results. This would likely influence thoughts about and efforts towards attitude change in the public. Apparently the public's response to the mentally ill is not determined by its knowledge and information but by its emotional reaction to the conditions under which mental illness so-called becomes apparent. This is an important consideration for the community development agent in his approach to the problem.

There are a few studies, though forming a minority opinion only, which claim that an accepting attitude has appeared (Lemkau and Crocetti, 1962; Crocetti and Lemkau, 1963; Crocetti, Spiro, Lemkau and Siassi, 1972; Crocetti, Spiro and Siassi, 1974). These studies have received severe criticism indicating their shortcomings (Sarbin and Mancuso, 1970), and furthermore, studies in which a distinction is clearly made between a psychiatric case, and deviantly acting persons not under psychiatric care (Crumpton, Weinstein, Acker and Anis, 1967; Phillips, 1963, 1964) make possible the conclusion that the public prefers greater social distance from mental patients. Lemkau and Crocetti (1962) felt that the public had been responsive to the professional leadership on the question of mental illness, and are now critical of the hypothesis that the public rejects persons who are diagnosed as mentally ill. However, as has been pointed out, their data can be readily interpreted:

> ... that the public is somewhat distrustful of mentally ill persons, but that the public is not particularly aroused by behaviors that psychiatric personnel would regard as signs of mental illness.
>
> (Sarbin and Mancuso, 1970; p. 166)

These authors conclude amongst other, that the public is not sympathetic toward persons who are labeled mentally ill, and would place a fair social distance between themselves and such persons. Yet, at the same time the public does not, contrary to the professional, label anything but the most exaggerated deviations as mental illness. If the public does not find it necessary to refer to most of deviant conduct as mental illness, one would expect to find a tolerance for deviant behavior expressed through the preferred mode of referral for a variety of cases and behaviors. An examination of the possible relationship between attitudes toward mental illness and preferred mode of referral may suggest or indicate a level of readiness by the public for the transition of the psychiatric patient from hospital care to community care. The attitude of the man in the street toward mental illness may be invoked to help find solutions to the problems. Sarbin and Mancuso (1970) state that:

> From the data at hand, the authors would predict his (man in the street) favoring a set of rules that would make obsolete the potentially derogating and disparaging employment of mental illness and mental health and the complicated medicolegal apparatus of psychiatric commitment, diagnosis, and hospitalization.
>
> (1970; p. 172)

In other words, the suggestion is that the public may be willing to assume responsibility for the mentally disturbed, and that their preferred model of mental illness may already, basically, be in agreement with the new community mental health ideology, thus greatly facilitating the move from custodial care to community care. To encourage this trend, and thus to strengthen the psychological sense of community, as well as enhancing the individual's ability to fulfill his personal and social choices as a fully accepted member of the community, is community development, and may suggest a discussion of the role of value conflict in social life, as the community appears to emphasize and give other social values considerable priority over the value of positive mental health.

Studies on attitudes toward mental illness have similarly been undertaken with regard to patients and their relatives. The general outcome appears to have been an indication that mental patients' attitudes are similar to non-patients'. A study of psychiatric patients under the Veterans administration in the U. S. A. reported that patients were no better informed about mental health and illness than the public, and their attitudes toward the mentally ill were strongly negative (Giovanni and Ullmann, 1963). In a study by Manis, Houts and Blake (1963) no significant attitudinal differences were found between medical and psychiatric patients. Crumpton, Weinstein, Acker and Anis (1967) reported that patients gave more favorable ratings than normals to concepts such as 'sick person', and 'mental patient', but that the mental patient was still seen in unfavorable terms. Social class differences in relatives' attitudes about mental illness and the patients were found by Hollingshead and Redlich (1958), though Freeman (1961) reports that social class was not a significant factor. It can be suggested that the difference may be due to differences in sample composition, or definition of social class. Freeman also reports that the patient's behavior after release from the hospital did influence his family's attitude about the chances of complete recovery and the extent of the patient's responsibility for his behavior. Amerigo Farina et al. (1964, 1971) report on some interesting implications of the patient's own perception of how others see him. The authors suggest that the rejection stigmatized people fear and expect is in part caused by themselves, and they ask, if in effect, the mentally ill person is a prisoner of his own reputation, real or assumed? Further research along these lines could have significance for the planning and for the preparation of the hospital patient about to re-enter the community. This again is of importance to the community development agent in his efforts to facilitate the transition both in general and in the specific instances, as well as in his effort in a preventive intervention.

As the most likely unit to receive a patient back into the community probably is his family, it is of interest briefly to review some studies dealing with the acceptance of the mental patient by his family. Whether the patient returns to his family home, moves to quarters of his own, or becomes a resident of some sheltered community facility or other, on his discharge from hospital, it seems the family to some extent becomes involved. Before hospitalization the family may initially be aware of symptoms, or unfamiliar and incongruent behavior. This naturally would cause anxiety, but at the same time a tendency to minimize or even to deny the presence of such behavior. As the disturbing behavior persists, anger or passivity may be expressed by the family, until such a time that the behavior interferes with and disrupts everyday routines. The result often is an encouragement to the patient to accept the "sick role", followed by hospitalization, either voluntarily or enforced. Though the relatives may initially attribute the disrupting behavior to character weakness, physical ailments or situational factors (Yarrow et al., 1955), the acceptance of the medical model as the behavior persists (Mayo, Havelock and Simpson, 1971; Freeman, 1961; Hollingshead and Redlich, 1958) leads to rejection and hospitalization. At this point the family appears to have accepted that their deviant member is mentally ill. With the patient hospitalized, the mitigating role that intimacy can play becomes minimized, and increasingly the patient is assigned a nonhuman quality (Goffman, 1963), and thus further rejection and isolation occurs.

On discharge the family must overcome such rejection if the patient is to remain within the family and in the community. This can not be achieved without strong community support to both the patient directly, and to his family. But in this, one must pay attention to the impact of some important factor, the impact of the source of help that is sought or provided. Phillips (1963) found that the rejection score was less when no help source was mentioned, but highest when the mental hospital was mentioned as the help source. This may suggest that families as well as the general public do not easily recognize cues for mental illness, or that they are more tolerant towards deviant behavior than are most professionals. They seem to need other cues, such as knowledge of help source, in order to define a behavior as mental illness. Therefore, their preferred mode of referral may be far more in line with community care thinking than is generally assumed, and it suggests areas for community development agents' intervention. Though fear of the patient has been suggested as a powerful factor for the rejection of the patient (Waters and Northover, 1965), the intimacy factor mentioned by Goffman may overcome such fear. Chin-Shong (1968) in a study of attitudes toward the mentally ill in an extremely heterogeneous urban American sample, found that family members with close ties to mental patients, were less rejecting even when they perceived him as dangerous, than were people without such ties. Tolerance of the deviant behavior may indeed facilitate the patient's stay in the community. Thus for example Deykin (1961) concluded that family and community tolerance for deviant behavior was one of the central factors determining a low recidivism rate.

Though the comment by Cumming and Cumming (1957):

> Mental illness, it seems, is a condition which afflicts people who must go to a mental hospital, but up until they go almost anything they do is fairly normal
>
> (p. 101)

may be exaggerated, nevertheless the expectations about accepting the discharged patient may be more pessimistic among family members than among the public at large, e.g. Swingle (1965), who reported that a trend exists for families to believe that patients would always remain patients. Rose (1959) also found that though verbally agreeing to discharge plans for the patient, many families became very much resistant and reluctant once the likelihood of discharge became a reality. Not all studies have found pessimism and rejection in the families of the mentally ill. Thus for example Freeman and Simmons (1963) found a high proportion of families accepting of the patient, and Brown et al. (1966) found 75 per cent of 251 families studied to be welcoming the patient home. Barrett, Kuriansky, and Gurland (1972) point to 60 per cent of families in their study expressing pleasure at the homecoming of the patient during an interview four weeks after discharge of the patient.

There are thus conflicting conclusions from studies concerning attitudes of patient's family. No doubt many more aspects must be studied. Thus for example economic and social pressures on the family, strain and demands of living with a former mental patient, family role of the patient, availability of community facilities, that are non-stigmatizing, to support and aid both the patient and the family, must be considered. Expectance by the family for high or low performance from the patient may be important for his chances of remaining in the community. It has been suggested that an acceptance of low performance regarding work and social participation would lead to fewer relapses and fewer rehospitalizations (Freeman and Simmons, 1958, 1959). Nevertheless, the stress of living with and caring for a symptomatic relative may become too great, and the mental hospital may then seem attractive (Mills, 1962). The patient can indeed use up the reservoir of good will held by the family (Pitt, 1969), especially if the family is left alone without community support. Thus the social cost alone of retaining patients in the community may seem too prohibiting a barrier.

Though some studies do indicate a hopeful, accepting attitude by families of mental patients, the majority finds a tendency to reject and isolate the family member showing deviant behaviors. This is especially true for the family accepting of a medical model of mental illness, and largely left unaware of existing sources of help apart from the custodial mental hospital. Social cost and strain on the family have often been cited as prohibitive factors for community care. It should, however, not be forgotten that most of the studies, if not all, necessarily have dealt with existing conditions and services, whereas a new base and a new approach are needed. A stronger psychological sense of community and a strengthening of community facilities may bring about a most welcome shange. Thus for the community development agent the challenge is not only for strengthening the resources of the family, and for the betterment of the existing service delivery system, but for encouraging a psychological sense of community, and for aiding, and instigating a change of attitudes toward mental illness and the "mentally ill", with resulting beneficial changes in approaches to the problem of mental illness.

Community Care And Mental Health Services In The Community

During a period in his life, Clifford W. Beers (1876 - 1943), had been a patient in three custodial asylums for the insane, where he had been treated with the typical non-understanding and the rigid responses of an impersonal institution. Thus Bloom (1963) in a resume of Beer's own description of his experiences, stated:

> What Beers describes as therapeutic progress, however, was not so interpreted by the staff of the several hospitals in which he was a patient. Rather, his change from a stuperous but quiet patient into an articulate, energetic, and assertive one was interpreted as an increase of disturbance. Similar experiences are described by virtually all the published autobiographical patient writings.
>
> (p. 191)

Based on the intense public reaction to his book, A Mind that found itself, (Beers, 1908), the mental hygiene movement was founded. Beers himself was mainly interested in improving conditions in the mental hospitals, but the movement was initially more of a pressure group seeking to stimulate action to solve the problems of mental illness. Later the aims of the movement became modified to seek to establish a program of eugenics to deny parenthood to those who were 'manifestly unfit', and to promote the likelihood that children would be provided with environments best suited to their development. The concern with intervention at the stage of childhood was expressed by the setting up of child guidance clinics by the National Committee for Mental Hygiene, which had been established in the U.S.A. in 1908. Its success was short-lived, however, as it was unable to arouse sufficient interest in suggested programs for prevention and aftercare for former mental patients. These areas today still remain our most urgent problems.

Following World War I, the demand for mental health services increased much as a result of the great interest in Freudian principles and practices, and psychoanalytical ideas and treatment approaches became influential not only in professional circles, but with the general public, simultaneously supporting and strengthening the medical model of mental illness. Yet some progress was made in the areas of early diagnosis and treatment of emotional disturbances (Stanford, 1965).

All the same, it was not until the outbreak of World War II, and as a response to the events of the war, that these problems came to receive more than a general and incidental attention (Dunham, 1965).

In 1946 the U.S. Congress passed a National Mental Health Act, which a few years later gave rise to the National Institute of Mental Health, which was able to award its first research grants in 1948. Much of this research has been on operant conditioning leading to behavior modification and behavior therapy programs. In 1972, the same year in which the new Alberta Mental Health Act was brought out, the National Institute of Mental Health directed about eight per cent of its research funds to research on, and evaluation of mental health services, but still more effort in this direction in the U.S.A. and in Canada, is needed.

In 1955, the Joint Commission on Mental Illness and Health was established, and five years later a report with recommendations for combating mental illness in the U.S. (Joint Com. Report, 1961) was published, placing great emphasis on the importance of the community. Sarason et al. (1966) commented that the report gave importance to the community as a potential arena for the engagement of mental health problems. This new suggested move toward the community with regard to attempts at dealing more effectively with mental health problems was based on several assumptions:

(a) a growing realization that confinement should not necessarily be thought of as for life. Such a realization lead to, and encouraged a philosophy of 'open door' institutions (e.g. Eisenberg, 1962; Williams, 1962; Greenblatt and Levinson, 1965),

(b) the introduction of new chemotherapeutic drugs in the early 1950's (thus Phenothiazine, the progenitor of Chlorpromazine, was synthesized in Germany in 1883, with Chlorpromazine itself being synthesized by a French chemist in 1950, and utilized in clinical trials in the treatment of schizophrenia, beginning 1951). This has been called "the outstanding single practical contribution to psychiatry in several decades" (NIMH, 1975). This lead to increased opportunities for direct treatment and aftercare in the community (Bellak, 1964).

(c) a continually increasing professional, and public awareness of antitherapeutic forces inherent in custodial institutions or in what has been called "total institutions" (Goffman, 1961), and

(d) the use of the hospital itself as a therapeutic community (Jones, 1953; Fairweather, 1964; Jarvis and Nelson, 1966).

In addition to this, Clausen (1966) has pointed out how in fact a change in etiological outlook has made it possible to broaden concepts of etiology to include poverty, squalor, and lack of education as being amongst numerous factors responsible for "mental illness".

An even stronger emphasis on the community, and a distinct move towards community care was made by the President of the U.S.A., John F. Kennedy, in his address to the Congress in February, 1963, when he called for a new type of mental health facility, the community mental health center. Caplan (1964) commented on this address:

> The fact of the message itself - the first official pronouncement by a head of government ... as well as its content emphasize that henceforward the prevention, treatment, and rehabilitation of the mentally ill ... are to be considered a community responsibility and not a private problem.
>
> (p. 3)

It was earlier pointed out that this move toward community treatment originated mainly from the discovery of and experiences with crisis intervention during World War II, where the assumption was that all mental illness would respond well to early treatment. The community mental health movement also was a reaction to the institutionalized and unpalatable conditions in the large mental hospitals. With this new focus, criticism arose against the slow and lengthy processes of psychoanalytical therapy. Being costly and aimed at the individual, this form of therapy soon became seen as economically discriminatory and class-bound. In its place various forms of group therapy began to assert themselves, and the need for highly trained professional therapists or helpers became questioned.

Nevertheless, it appears that the central aim of the community mental health movement has been the direct attack on the "illness" model (Szasz, 1961), and it is in fact a major response to this internal crisis within psychotherapeutical circles. It has been characterized as "the third psychiatric revolution" (Bellak, 1964), as the "third phase" (Group for the advancement of Psychiatry, 1962), and has been known variously as public health psychiatry, social psychiatry, preventive psychiatry, and community psychiatry (Baker and Schulberg, 1967; Rabkin, 1972, 1974).

It has been a suggestion from the community mental health movement, both as expressed in the U.S. Joint Commission Report (1961), and in the Canadian Mental Health Association's, More for the Mind, (1963), that people with psychiatric illness should be able to obtain treatment as easily, in the same way, and without loss of social benefits, as do patients with other illnesses. There has thus been attempts made to change the locus of mental health care from large centralized mental hospitals to board operated regional health facilities. This is noticeable in the significant changes in the Province of Alberta, which since 1970 has adopted the community mental health model as a response to the Blair (1969) report, and expressed in the Alberta Mental Health Act (1972).

Though community mental health is concerned with the de-emphasizing of the large mental hospitals in favor of a provision of integrated mental health care facilities in the local community,

> this third revolution in mental health may
> have misfired into an urbanized version of
> the state hospital
>
> (Smith, 1968)

and in fact not as a truly innovative change toward a mental health service, broader in scope than hitherto. Because of this danger, it is, therefore, imperative that efforts be exerted to aid and facilitate a move towards a true community care position, and the community development agent here is presented with a challenge and at the same time an opportunity to encourage and nurture a psychological sense of community.

As part of the new arrangement, seeking to provide integrated mental health care facilities in the community, the out-patient clinic arrived in psychiatric treatment, though as Forstenzer (1961) points out:

> ... but it failed to prevent hospitalization and deterioration. The clinics were pleasant to work in, located in the urban centers, attracting qualified staff, and attracted a new type of patient, not on the whole very ill.

The poor were left out, and it has been the middle class that has found the new type of clinics and centers a way to augment their supply of mental health services.

Nevertheless, it can easily be seen that from the beginning of this century, there has been a persistent shift of psychiatric care toward the community position, and a community mental health model for the delivery of mental health services. Generally facilitating this acceptance of the community mental health ideology is that, in Alberta, as in all of Canada, it is following examples of similar institutions in neighboring provinces and countries. As well, it is directly responding to an increased public demand for the mental health service to become more socially relevant. In favor of community mental health services is of course also the increase in status now associated with community work. On the other hand, amongst factors working against an acceptance of the community mental health ideology can be seen a fear that a drastic reduction of patient population in the large mental hospitals could threaten job security for a significant number of employees. Another factor is the fear that the existence of the mental hospital as a major economic base for a community may be threatened. Fear of the ex-psychiatric patient in the community may be a factor, but is probably more a result of the inadequacy of existing facilities in the community for the continued care of the "mentally ill".

Detailed accounts of the development of community mental health can be found in Rossi, 1962; Hobbs, 1964; Bindman and Spiegel, 1969; Caplan, 1969; and in the large, comprehensive textbook of psychiatry by Freedman, Kaplan, and Sadock, 1972 and 1975.

As previously indicated, people with persistent psychopathology can function outside of the large mental hospitals. Thus, according to a statement in Canadian Mental Health (1965), some

95 per cent of the general adult psychiatric cases can be treated without hospitalization, and be maintained in the community with adequate treatment and supportive services. Therefore, an interest in early and ambulatory services has developed. Increasingly there has been an emphasis on treatment services in local areas.

Community mental health care, or community mental health organizations, is at present in fact a network of programs and services; a development of services that offer mental health care to people in the community at the local level. It is thus concerned with providing psychiatric services in the community, by the community, and staffed by personnel functioning in the same way as other personnel in similar services in that community.

Characteristics of Community Care

Various characteristics distinguish community care from other parts of the public mental health delivery system (e.g. provincial mental hospitals, out-patient clinics, or psychiatric units of the general hospital) namely:

(1) the concept of the catchment area. This refers to a specific geographic area to be served, and to the location of facilities. The principle behind this concept was that it would allow for more accessible services, located within the community rather than in

distant areas. In this way users and their families could obtain service in their own community, and programs offered could more easily be shaped to meet community needs. Further, catchmenting allows for increased community participation in decision making, which is in agreement with a basic principle of community development. The size of the catchment area has been a much debated topic, and has somewhat arbitrarily been suggested as covering a population between 75,000 and 200,000 as the upper population limit in metropolitan areas. This may easily be too large for most areas, and some neighborhood health centers in the U.S. concerned with maternal and child health programs have been considerably smaller - 10,000 to 50,000 persons per area (Klerman, 1974). In practice, catchment areas have been defined on the basis of counties, municipalities, and in terms of existing boundaries, e.g. major highways, rivers, etc. (Huffine and Craig, 1973). Unfortunately as it is at present, the catchment area is not synonymous with community, and the desired community of therapeutic value, family and friends supporting the disabled and encouraging their reintegration into the community, has not yet appeared. Whether in fact the catchment area concept has produced an improvement in mental health community care, and a more rational system of coordinated services, is more difficult to assess. Various studies (e.g. Riedel et al., 1971; Tischler et al., 1972; and Goldblatt et al., 1973) have indicated that the setting up of catchment areas has increased utilization of local services, though its effect on rate of admission to the large mental hospitals has been more difficult to assess. It does appear, nevertheless, that use of the concept of catchmenting has resulted in better crisis intervention, and a higher consumer satisfaction. More research in this area would be welcome and useful. Further the concept of the catchment area has significance for the question of relocation and aftercare of ex-psychiatric patients to the community. As the catchment areas are not interchangeable with communities, some neighborhoods may become saturated with ex-patients, and the goals of community responsibility and the community as a therapeutic agent may be lost because of a biased distribution of former mental patients.

(2) Community care must cover the total mental health needs of a community, which means that the community member must be able to obtain a wide range of care, and such as most appropriate to their situation and problems. Thus the community mental health centers in the United States are required to provide a comprehensive service, consisting of: inpatient care, outpatient care, emergency care, partial hospitalization (day-care), and community consultation and educative programs. In addition to these, it is recommended that specialized diagnostic services be provided, rehabilitative programs, precare and aftercare, i.e. preadmission and postdischarge services for mental hospital patients, training and educative activities, as well as intensive research and evaluation programs.

(3) The various services offered by community care are meant to be offered in a coordinated fashion. Thus it should be easy for the consumer of the services to move from one type of service facility to another as the need arises. Services should be coordinated to provide a continuity of care and to liaise with a variety of other types of service available in the community, such as schools, churches, welfare agencies, local courts, etc. Such might best be achieved through a community mental health center. In Canada, approximations to this have been suggested by Dr. John E. Hastings in his report on the community health center. The report (Hastings, 1972) sees the community health center as a major means of solving such problems as the high cost of services, the inadequate accessibility to and distribution of health resources, and the fact that human services in general (i.e. health, reform, education, and social services) are inefficiently separated, and often compete with each other for funding, clients, and other resources. The centre is seen as serving between 6,000 and 9,000 people depending on population density, local resources, and special needs. In spite of the innovative ideas of the report in general, its mental health recommendations are vague and insignificant. In consideration of the fact that psychiatric patients occupy about forty per cent of the hospital beds in Canada (Freeman, 1975), a statement by one of the major consultants to the project:

> as regards social services (including the services of psychologists and community mental health workers) their introduction into medical groups or community health centres will depend on policy
>
> (Ruderman, 1972),

as well as the fact that the Hastings report describes the role of mental health services in only ten and a half lines (p. 42), the effort clearly falls far short of anything even remotely adequate as a suggestion for a coordinated care system.

If community mental health care is to be provided through a community mental health centre, various models should be suggested. Thus the centre could be within an already existing mental hospital, or within a general hospital. This no doubt would be the least successful model to accept as it would most likely become a continued institutionalized service with all the pitfalls of the large mental hospitals of the past. Advantages of such an arrangement could be that all routine support services (purchasing, housekeeping, maintenance) are already provided by the hospital, thus not necessitating any extra funding or staffing. Easy access to the many medically related facilities would be available in a general hospital. More likely, the centre could consist of a consortium or a collaboration of private agencies. This would ensure maximum use of multiple existing facilities, freedom from civil service bureaucracy, and flexibility and rapid response in program development.

Again, the centre could be connected with academic psychiatry and other departments of a university concerned with mental health. The emphasis in this type of model would be an integrated system of service, training, and research. A combination of the last two models could prove immensely valuable.

(4) Community care is intended to emphasize preventive activities. It is aimed at teaching or aiding individuals and groups in the community to better cope with the stresses of everyday living, before such stresses can cause severe disability in the individual or the group. There must be an active effort to identify high-risk populations, and to provide the necessary supportive help to such through community education programs and a variety of other mechanisms. Community care must seek to mobilize all of the community's resources to promote mental health, and to reduce the incidence of new cases of emotional disorder, or "mental illness", through attention to and utilization of primary prevention principles. However, though Caplan (1964, 1970) enthusiastically has described prevention, no one appears yet to have been able to demonstrate a real preventability of mental illness, though enlightened social planning has been shown to diminish the occurrence of a very few conceptually straightforward disorders (Carstairs, 1958). That most conditions in psychiatry: "are too obscure to allow for effective prophylactic work", is held by Henderson (1974). If, however, community care is to be truly in, and of, the community,

it must concern itself primarily with prevention, which in order to be successful will necessitate a wide acceptance of the new community mental health ideology, both by professionals, and by the lay community member.

Thus in place of large institutional mental hospitals, it is proposed to establish a community-focused mental health service with services provided, tailored to the needs and particular problems of the community in which it will function. Community care is extensively dependent on the community understanding of its own needs, and on the mental health ideology to which the members of the community agree. It is, therefore, important as part of a community development intervention at this point to obtain information about the attitudes to mental illness held by the majority of community members. Equally necessary is it to know how widely a community mental health ideology is accepted by the members of the community. Thus it was thought desirable to assess the present position with regard to these questions in the community, the preferred mode of referral, and to seek to find community development strategies especially applicable to the present problems. It was thought that such community development strategies would aid the community in achieving necessary changes in relation to the suggested move, to facilitate and ensure its success. At the same time this was seen as an opportunity for the community development agent to encourage and strengthen a psychological sense of community. This was thought to be a first step toward preventive community development interventions of benefit not only to the local community, but with implications for regional, national, and international community development interventions.

The concept of community care has arisen out of a particular concern for the quality of care provided in the public mental health system, especially as thoughts and efforts at reform intensified after World War II. A more decentralized, community-based service delivery system has been envisaged, and it is in the process of being established both for children and adults. A comprehensive range of services are attempted, and facilities for such are continuously being established in the communities, though as yet they are far from being adequate. Caplan, in discussing community planning in relation to the concept of preventive psychiatry, suggests that a number of units must be included in a comprehensive program. He lists these under the headings: The program and the family; Domiciliary psychiatric service; Central record room; The local mental health center; Psychiatric outpatient clinic; Community mental health center; General hospital psychiatric inpatient service; Mental hospital admission and treatment; Day hospital and night hospital; Rehabilitation service; Service for patients with residual defects; Transitional institutions; Foster homes; Sheltered workshops and supervised industry; Psychiatric social clubs; and Community organization: "as an integral part of each of the units previously listed". In addition to these units, specialized agencies dealing with mental subnormality, alcoholism, drug addiction, and delinquency owing to mental disorder, should be provided within the comprehensive community care service (Caplan, 1964; pp. 144 - 150).

Eight Basic Service Components of Community Care

Assuming and accepting that community care should not be just an extension of existing psychiatric services into the community from the large mental hospitals, it can be seen to cover eight basic service components. All of these are to be provided with the emphasis on decentralization, and can be viewed as comprising a clinical continuum:

(1) Consultation and Education. In general this service should be the initial intervention of choice in a community mental health delivery system. It is a method which has emerged from clinical practice. The National Institute of Mental Health (1971) defines consultation as:

> Mental health consultation is the provision of technical assistance by an expert to individual and agency caregivers related to the mental health dimensions of their work. Such assistance is directed to specific work-related problems, is advisory in nature, and the consultant has no direct responsibility for its acceptance and implementation.

Though some consultation by mental health professionals at present does take place in the community, this remains a relatively underdeveloped service. In the mid-twentieth century mental health consultation tended to involve the consultant directly with the client or patient. Then the first paper on mental health consultation in the form in which it is now best known, was published by Jules Coleman (1947). In this paper the model was that the consultant did not focus directly on the problem to be solved, but aided the consultee to deal with the client or patient. Following this paper were several others describing similar models as used by Coleman (e.g. Susselman, 1950; Maddux, 1950; and Berlin, 1956, 1960, 1964). One of the foremost representatives and major conceptualizers of mental health consultation as a unique community mental health tool has undoubtedly been Dr. Gerald Caplan. In several writings (e.g. Caplan, 1959, 1964, and 1970) he developed and presented a precise and practical model for mental health consultation, which rapidly became the standard against which others measure their consultation activities. Caplan's model has given rise to some controversy, and some criticism. Some of these have been clearly summarized and the model itself described as "essentially an elitist model of consultation" by Lydia Rapoport (1971).

For the future, greater emphasis on this service is desirable and especially in the category known as program consultation. Up until recently most consultation has been of the client-centered category. Only during the last decade or so has program consultation been attempted in earnest. In this type of consultation, the emphasis is not on the individual client and his problems, but on problems of planning, development, management, evaluation, and coordination of services directly or indirectly affecting the mental health of the community.

In addition to administrators and planning staff, it should be possible to utilize former psychiatri patients in program consultation, as this group of community members have highly relevant knowledge and experience. Groups that would benefit from consultation can be found amongst community gatekeepers or indigenous nonprofessionals, parents of problem children (Guerney, 1964), and of course the various mental health agents (Kelly, 1964). New models of consultation could be developed. Thus, for example, it can be noticed that the approach and techniques of mental health consultation are remarkably similar to those of behavior therapy. There could no doubt be significantly beneficial results from development of mental health consultation with and within a behavior modification approach. Though much has been written about mental health consultation, the absence of such development appears as yet too notorious. An interesting, and for community development agents, promising approach has been suggested by Abramovitz (1958), who is taking issue with our present culture, seeking a culture change related to the issue of reality of emotions, and emphasizing individually determined morality. However, as pointed out by Bennett et al. (1966), mental health consultants are very much divided over the issue of whether as professionals they should remain within traditional roles, or whether, and to what extent, they should become political activists. Nevertheless, there can be no doubt of the increasing potential future value of mental health consultation as a service within the community.

In order to prepare and energize community members for changes in their attitudes to mental illness, their ideological assumptions, and to assist agencies to expand and upgrade their roles in the community's mental health maintenance system, programs of mental health education are needed.

The National Institute of Mental Health (1971) defines mental health education as:

> Mental health education is the dissemination of knowledge related to issues and behaviors which contribute to individual and community mental health and mental health breakdown; and knowledge of resources and skills for the achievement of mental health and the management of mental illness. Mental health education includes both theory and practices, general knowledge and training in specific job or taskrelated skills.

Mental health education efforts especially should be provided in relation to the sociology of the community and the geographic responsibilities of other human service agencies. It must be directed toward community organization and advocacy, and special attention should be paid to the value of education service in furthering continuity of care when more than one human service agency is involved with a client. Previously the emphasis has been on helping the individual gaining insight into the nature of his "inner" conflicts and finding ways of resolving them. This was intended to enable him to adjust to the community which was seen as a fairly static system. Presently the community is seen as a much more dynamic system, and the focus has shifted from the individual to a focus on the total community. This has also meant that a treatment-oriented approach to the community member with problems has been superseded by an approach emphasizing "collaborative and coordinate education and information and growth and development-oriented relationships with client systems" (Adelson, 1970, pp. 7 - 28). Naturally this does not mean that the goal of increasing the knowledge and capacity of the individual to cope effectively with problems and crisis as they arise in his life, should be ignored. It does mean, however, that in the future, increased attention should be paid to increasing the knowledge and capacity of the community (both as a totality and as a set of subsystems) to cope effectively with social problems. The approach and skills of the community development agent may be of special value in this regard, as he will be particularly concerned with the issues of social change and preventive intervention. Any subsystem of the community may become and be seen as a target group for mental health education, and the mental health educator may find it necessary to establish priorities guiding him in where to focus his energies and when. An outline of criteria for selecting groups have been suggested by Adelson and Lurie (1972, p. 523) which takes into consideration three factors, i.e. vulnerability to emotional disorder, ability to control change, and degree of care-taking functions. Goldston (1968) has suggested that some mental health education functions must be performed by "specialists", i.e. professional training, general education programs, consultation to mental health centre staff, staff in-service education, etc. Some functions, he suggests, can best be performed by "generalist" community mental health workers, which includes community development agents, and indigenous non-professionals within the community. Such functions are: community organization, community analysis, identifying foci of mental illness, and establishment and provision of mental health consultation. For the purpose of planning and practice of mental health education, it is important to be aware of the accepted ideological assumptions of the members of the community. This study, therefore, sought to assess the present level of acceptance in the community of a community mental health ideology, as all issues in the question of community approaches to the problem of mental illness are related to and may be determined by the attitudes and dominant ideology of the community.

Important for the community with regard to the question of cost, is that personnel providing consultation and education services need no separate facilities, though some office space may be required. Such space can often be made available in community agencies serviced, and/or in already existing facilities, ensuring decentralized service in closer contact with the community.

(2) Emergency Services. Accepting the variety of the concept of early and direct intervention, the emergency aspect of community mental health is of outstanding importance. Yet, at present very few emergency psycho-social services exist in suburban and rural areas. There is obviously a need for developing techniques of effective crisis intervention, but a paucity of information on how to structure such a service with necessary network linkage.

Fowler's (1964) Concise Oxford Dictionary defines "emergency" as: "a sudden juncture demanding immediate action", which again suggests the importance of environmental factors in crisis situations. Ways in which to handle psycho-social emergencies and crises are as many and as varied as there are institutionalized styles of human relationships. Yet there is a need for systematic planning which generates the needed support of all important community elements (McGee, 1974). This again is an area in which the special approach and skills of the community development agent could be utilized.

It is only within the past few decades that the crisis approach has been developed. Its theory is rooted in outlines of human behavior as suggested by Sigmund Freud (v. Bellak and Small, 1965), Heinz Hartmann (v. Loewenstein, 1966), Sandor Rado (v. Salzman, 1962), and Erik H. Erikson, whose theoretical formulations concerning identity crisis and identity have provided a basis for the work of others. In part crisis teory developed from a study by Lindemann (1944) of bereavement reactions of family members of those, who died in the Coconut Grove night club fire in 1942. Lindemann found that it was the speed with which the grief process began and was worked through then, that determined the early positive outcome for the person involved, or abnormally prolonged reactions as the result of a loss of a significant person in their lives. Lindemann suggested that during many inevitable events in an individual's life-cycle, emotional strain would be generated, and that the individual would meet these through the use of a series of adaptive mechanisms. This could in each situation either lead to mastery, or to failure accompanied by lasting impairment of functioning. To further explore the implications of his findings, he and Caplan in 1946 established a community-wide program of mental health through the Harvard School of Public Health. This was called the Wellesley Human Relations Service Project, and was a forerunner for several ideas about the delivery of innovative community mental health services (Klein and Lindemann, 1961). Caplan continued this line of work, and evolved the concept of the importance of crises periods in individuals and in group development (Caplan, 1961).

In 1958 a "Trouble Shooting Clinic" was started by Bellak (1960) as part of City Hospital of Elmshurst, New York. This was a walk-in clinic operated around the clock. In 1962 the Los Angeles Psychiatric Service opened the Benjamin Rush Center for Problems of Living - a no-waiting, unrestricted intake, walk-in crisis intervention centre. In 1967 crisis intervention replaced emergency detention at San Francisco General Hospital. A follow-up study by Decker and Stublebine (1972) indicated that the program had resulted in a reduction in psychiatric inpatient treatment. In the early 1970's, suburban churches in Montreal, Canada, offered brief crisis intervention (Lecker et al., 1971). Hot lines and youth crisis centres were set up - yet, it was not until the fourth edition of Hinsie and Campbell's Psychiatric Dictionary, (1970), that crisis intervention was listed;

> In the crisis intervention model, the focus is on transitional-situational demands for novel adaptational responses. Because minimal intervention at such times tends to achieve maximal and optimal effects, such a model is more readily applicable to population groups than the medical model.
>
> (p. 606)

Emergency services, or crisis intervention, may be provided through neighborhood walk-in clinics, telephone hot lines, crisis counseling by bartenders in taverns and lounges, or by hairdressers and taxi-drivers to their customers; it may be provided by the police department, clergymen, and acute psychiatric services of general hospitals. All community elements and resources may be utilized - family agencies, business organizations, volunteers, non-professionals, and professionals of all kinds. The skills of the community development agent can be seen as particularly suitable for aiding in organizing and expanding a network of emergency psycho-social services.

(3) Ambulatory Services. This refers to what more traditionally had been known as outpatient services. However, as community care with its emphasis on decentralization becomes more established, the greater mobility of staff providing such services, and of clients receiving them suggests the more appropriate: ambulatory services. Their main functions are to seek to keep the client functioning, and outside of a hospital setting, to assist the family as part of the client's problem solving, and to foster client rehabilitation and psychological growth. The services offered are delivered within the philosophy of outreach, prevention, and early identification. At all stages attempts are made at fully involving the clients and their families in the process. The variety of services offered can be grouped into three categories as indicated in the following, adapted from the publication by the National Institute of Mental Health (1973):

(a) Information, screening and referral services. Information provides data about the availability of crisis intervention and other services; screening refers to the assessment of eligibility of a person for another organization's services as well as the type and extent of the problem of the client. Referral services guide or link the client to other appropriate community resources.

(b) Problem evaluation, examination, and assessment services. These services identify the nature and extent of the client's condition, and outline a plan for services.

(c) Treatment and counseling services. This category is characterized by great flexibility in the services provided. Thus it can cover supportive psychotherapy, play therapy, hypnotherapy, behavior modification, counseling, couple therapy, family and group treatments of different types, chemotherapy, and social system psychotherapy, etc.

The increasing use of volunteers, paraprofessionals, and former clients (for example for homevisiting, orientation to treatment and assessment procedures) ensures the community-oriented aspect of these services. Both centralized and decentralized facilities are needed. Some clients may prefer the more visible centralized facilities, but away from their immediate neighborhood, whilst others prefer the greater accessibility of services within the neighborhood setting.

(4) Day and Evening Treatment. This service provides an alternative to hospitalization. Not only can the day/evening treatment centre be seen as an intensive treatment setting, but it can provide an open-ended, long term resocialization and rehabilitation experience without residence in an institutionalized setting. Thus the service will function on two levels: Level I (intensive and acute), and level II (long-term and chronic). The efforts of this service are aimed at facilitating community reentry and adjustment for the client. The center, wherever located, will provide a variety of large and small group activities placed within a therapeutic community which permits a client to find his own maximum level within a 'self-actualizing' group. The service will seek to encourage client self-reliance, and its physical facilities should be located in the center of the community, to avoid isolation. It should serve ten to seventy clients at a time (Veterans administration, 1974). At present this service within community care tends to remain underutilized.

(5) Vocational Rehabilitation. Any person who for a longer or shorter period has been disorganized and alienated through an episode of "mental illness" will to some extent have disrupted his work pattern. Vocational rehabilitation is a service provided by the community in order to help the individual once again to function

at the highest level at which he is capable. Through a carefully supervised and guided work-rehabilitation the client can be helped to restructure unacceptable behavior and develop self-reliance and confidence. The process must take place as far as possible within the community itself, and various programs of more or less direct community involvement have been offered. Thus can be mentioned: occupational therapy, sheltered workshops, hospital work training programs, primary manufacturing workshops, patient-run enterprises, on-the-job training and vocational education, etc.

(6) Social Rehabilitation. For those clients unable to participate in vocational rehabilitation this service is offered in the hope of helping (especially the ex-psychiatric patient) clients to improve upon their abilities to cope and adjust within all types of social situations. Its emphasis is on remotivation, resocialization, skills of daily living, and recreation.

(7) Community Residences. Traditional hospitalization has been found costly and at times antitherapeutic. This service seeks to find less traumatizing, alienating, and expensive forms of residence than are the institutional, large mental hospitals. Community residences are seen serving as effective alternatives in providing sheltered living arrangements for those returning to the community from the large mental hospitals, and for those already in the community, but who have become in need of short-term, intensive,

non-medical supervision and support. Different kinds have been established. Thus there now exists group residences, halfway houses, cooperative apartments, foster families, and intensive care residences for crisis management on a 24 hour basis.

All types of community residences should be related to the community in which they are located through participation of the occupants in community board meetings where appropriate, or on community advisory boards and committees. It is desirable that each facility should be managed with as much administrative autonomy as possible, preferably with decision-making participation of the residents. Residents should be encouraged to utilize community facilities, i.e. transportation, shopping areas, recreational facilities, health and social service agencies, etc., much as do other community members in the area. As far as possible, linkage with community mental health aftercare (outpatient) programs available in the community should be maintained to provide required follow-up, evaluation, and crisis intervention.

(8) Hospital Care and Treatment. Though hospital care has been severely criticised it must nevertheless be recognized that the hospital itself belongs to and is part of the community. Thus to some extent it is an artificial division to place the hospital as being outside the community. Therefore, hospital care and treatment is a service offered as part of community care. The

future role of the hospital appears to be as provider of facilities for brief in-patient treatment when the patient's medical needs can be met only in a hospital setting; when the security of the patient, his relatives, or the community requires 24 hour care, or when there can be found no other facility providing adequate around-the-clock observation.

There is thus a move toward community care for the "mentally ill". However, if community care is seen as nothing more than the extension of various forms of psychotherapy to include new categories of people even though at the same time reducing admission rates to the large mental hospitals, it has failed. It appears that if the community is to meet its responsibility toward those of its members at any time afflicted by "mental Illness", the community and its members must aspire to achieve and accomplish much more than that.

Rather than retaining a rehabilitation approach, which is based on the premise that the condition of the mentally ill is at present irreversible, and that the appropriate treatment approach, therefore, must be to seek to help the client live with his condition, community care should be based on an educational approach (Mechanic, 1968; Torrey, 1974). This model states that the clients lack information, skills and abilities that are important in satisfactorily adapting to the community life, and to cause desirable social change. Community care, therefore, must offer job advice, health and legal assistance, because many of the difficulties, people experience, are a result of deficiencies in skills and lack of information needed to redress their problems (Riessman and Hollowitz, 1967). This necessitates the entry into the community, or the emerging from within the community, of behaviorally oriented educators and problem solvers. Among these can be found the community development agents.

The focus of effort moves from the individual and from attempts at exclusively changing the individual to fit into or adjust to the environment - to a concern with helping to alter the social conditions under which community members live. Skinner (1952, 1971) has stated that populations, as well as the individual, operate under social-environmental contingencies, which selectively reinforce behaviors. It, therefore, seems natural to suggest a closer concern with such social-environmental contingencies when considering community approaches to the treatment of mental illness. Dörken (1971) said:

> By attending to social conditions, indeed, to the structure of society we could focus on the seedbed of much that we classify as mental disorder,
>
> (p. 80)

thus supporting strongly a behavioristic, Skinnerian approach. Operant conditioning principles, behavior modification approaches in applied settings, and social engineering can thus be seen to be extremely valuable aspects of preventive community development interventions seeking to establish community care and a psychological sense of community.

Community Development Strategies

There has been, and continues to be, much effort expended in attempts at reaching a definition of community development, which can be satisfactory and acceptable to all. The definition as adopted by the United Nations in 1956 from the 20th. report to ECOSOC of the UN Administrative Committee on Coordination, states:

> The term community development has come into international usage to connote the processes by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social, and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress.

The validity of this definition was reaffirmed by the UN, Department of Economic and Social Affairs (1971). Thus, community development involves modification in social systems and/or subsystems in structure, functioning, or process over some time. It includes modification in transmitted and created content, patterns of value, ideas, and other symbolic-meaningful systems as factors in the shaping of human behavior, and the artifacts produced through behavior. Community development is associated with increase in size and complexity over time. It is a move towards more symbolization, in line with what has been suggested by Etzioni (1968; pp. 198 - 199) for the 'active' society, by means of which the range of communication, control and direction, as well as the emergence of new properties is enormously increased.

Community development, however, is not confined to modifying existing systems, but must also include designing new, experimental social systems with provisions in both cases for corrective feedback about the effects of intervention. It must involve long-range planning; long-range effective social planning by community groups. Thus it becomes a preventive intervention in which members of the community utilize current resources, create new resources, and link to a maximum number of constituencies within, and to other community development efforts outside. The primary objective of community development is to promote popular participation and involvement in the development process. Thus community development is people-involvement in decision-making and problem-solving at an increasing rate in numbers of people involved.

Community development must be a dynamic interaction between a central government and a smaller community, i.e. non-global - thus ensuring that the process of development in all spheres takes place as an integrated process involving and encompassing in every instance an overall planning process for the global community of man. Each example of community development should be seen shifting boundaries in the direction of world society. Therefore, some of the distinguishing characteristics of community development can be seen to be:

(1) People participation in increasing numbers
(2) Movement from versatility to efficiency
(3) Causing changes in social institutions so that they are more facilitative of individual needs
(4) Move towards increased symbolization
(5) Shifting the boundaries in the direction of world society, and finally, in all cases -
(6) Provision for pre-intervention measures, and ongoing camparisons for the purpose of evaluation.

Perhaps most simply stated, "community development would become the human phase of every improvement effort" (Biddle, 1966; p.12).

It would, therefore, seem to be fruitless to search for the approach or strategy with which to solve our problem. Further, it has become apparent that there are no strategies, nor techniques, exclusively specific to community development, only principles. Arthur Dunham suggested eighteen basic principles derived from a total of 142 statements. Another frequently quoted list of principles was produced by Joseph Di Franco at Cornell University (Di Franco, 1958). Finally a comparable list can be found in a UN publication from the Department of Economic and Social Affairs (UN, 1971).

Any strategy adopted for utilization in a community development effort should as far as possible be in consensus with as many of these principles as possible, though here again flexibility must be the outstanding characteristic.

According to Dunham (1970): "Community development is always concerned with bringing about social change", and the goal for community development can thus be seen to be to create opportunities for a community to plan for its own change, for its own future. The community development agent thus is concerned with preventive intervention in developing criteria for the community to employ when setting goals for its own future. Community development thus looks toward strategies utilized generally in social change for its own processes.

As there is no agreement on the way to go about inducing change, one can find a veritable grab-bag of change strategies of varied value. Many authors have concerned themselves with the question of strategies within the general process of decision-making. Basically this process involves:

(1) a search process to discover goals
(2) the formulation of objectives after search
(3) the selection of alternatives (strategies) to accomplish objectives
(4) the evaluation of outcomes.

(Scott and Mitchell, 1972;
p. 165)

Perhaps, when concerned with community development, one should more precisely talk of the intervention process rather than a process of decision-making, though the stages remain very much similar. What is desired is an intervention into the community resulting in some positive change.

Pointing out, however, that the change itself is not a primary task of the interventionist, Chris Argyris (1970) states that:

> To intervene is to enter into an ongoing system of relationship, to come between or among persons, groups, or objects for the purpose of helping them.
>
> (p. 15)

According to Rolf E. Rogers (1975):

> an intervention is a strategy for moving into an existing organization or system, examining its relationship with the environment, and bringing about appropriate change.
>
> (p. 208)

Rogers suggests six definable stages in the intervention activity, i.e.:

(1) the "need" phase, in which it is recognized that some

change is required,

(2) initial diagnosis, in which the present state of the organization is examined with regard to its various subsystems, including also its environment,

(3) deciding change goals and underlying reasons for the need for change, (suggested by Lawrence and Lorsch, 1969),

(4) strategy or action planning, in which variables to be altered are identified, and direction of the change action decided upon,

(5) action, in which the selected strategies are implemented,

(6) evaluation/feedback, in which participants analyse progress toward goal attainment.

(pp. 209 - 211)

Some authors have been concerned with providing outlines for community action, suggesting a series of steps through which attempts at intervention should move. Thus for example, Eduard Lindeman (1921) as one of the earlier authors suggested ten steps with their main emphasis on creating an awareness of need within the community. Later Thelen (1954) sought to illustrate in outline the passage of an idea from an individual through an organization, and via interorganizational cooperation, to eventual adoption into the culture of the community. Thus he emphasized the essential interdependence of groups in the community.

H. A. Simon (1955) emphasized the importance of participation in planning stating:

> Significant changes in human behavior can be brought about rapidly only if the persons who are expected to change participate in deciding what the change shall be and how it shall be made.
>
> (pp. 23 - 24)

A similar emphasis as in Thelen can be seen in a model developed by a social science team in Michigan (Sower, 1957). Concerning itself with the study, planning, and organization required before any action is set in motion is a model developed by Frank Sehnert (1960) from experience gathered in the Southern Illinois University community development program. This model relies heavily on a university-provided consultant's efforts.

Powell and Benne (1960), involved with adult education, considered two basic approaches to change, i.e. a developmental and a rationalistic strategy. The first strategy requires an active participation of the community members in planning and organizing. The importance of participation was emphasized also by Guest (1962), who was concerned about the possibility of conforming, "to unfocused pressures from higher management, parents, or universities", a process referred to as well by Shepard and Blake (1962). The second strategy requires a utilization of communication and informational, reasoned argument, and assumes that change will occur as a result of such utilization. Becoming more specific, and more directly relating strategy to goals and structure, Rein and Morris (1962), specify two strategies for change which they term: cooperative rationality, and individual reationality. The authors state that the cooperative rationality strategy has the following characteristics: consensus, legitimacy, rationalism, avoidance of controversy, and a fusion of ends and means. It appears that much of community development efforts up until today have been and are based on this strategy, according the process of involvement a high degree of sacredness. In contrast to this, the individual rationality strategy is less dependent on consensus, and more directed by predetermined, specialized, vested interests. Though the strategy is utilized for the community interest, there is a prior belief in the correctness of each objective. The authors suggest that this strategy is best suited for introducing new ideas where diversity or pluralism will be encouraged. Cooperative rationality, on the other hand, is best suited to create conformity, to attempts at having common goals and standards accepted.

In the same year, R. Chin and K. Benne outlined three types of strategies, which they called the rational-empirical, the normative-reeducative, and the power-coercive strategy (Benne, Benne, and Chin, 1962). The rational-empirical assumes that men are rational, and that change will take place as information is provided This is very much similar to the rationalistic strategy considered by Powell and Benne (1960), and also to the cooperative strategy of Rein and Morris (1962). The normative-reeducative strategy similarly assume that men are rational, that they will act on the basis of social norms, seeking knowledge and seeking to utilize environmental resources in order to satisfy their needs. Thus this strategy suggests the appropriateness of participation in decision-making by members of the community. This strategy compares to the developmental approach of Powell and Benne, and again to Rein and Morris' cooperative strategy. Lastly the power-coercive strategy assumes that man acts on the basis of power relationships. This strategy is somewhat comparable to Rein and Morris' individual rationality approach, and emphasizes political and economic legitimization for action.

According to Matthew Miles (1964) the most efficient strategies were said to have the following characteristics:

> (1) comprehensive attention to all stages of the diffusion process,
> (2) creation of new structures, especially by systems outside the target system,
> (3) congruence with prevalent ideology in the target system, such as beliefs about the importance of "local control",
> (4) reduction of pressures on relevant decision-makers, and
> (5) use of coalitions or linkage between existing structures, or between old and new structures.
>
> (p. 648)

Then in 1967, Robert Chin attempted a precise definition of strategies:

> Strategies of change is interpreted as including, but not limited to, dissemination and provisions for utilization of pertinent information regarding all aspects of the proposed plan; ways of identifying and dealing with internal and external (environmental) constraints as well as facilitating influences; ways of identifying potential opposition, conflicts and tensions and of resolving them advantageously; appropriate means of helping individuals, organizations and agencies to effect needed change in their perspectives; and procedures (guidelines) for implementing proposed change.
>
> (p. 40)

A few years after Chin and Benne (1962), Richard E. Walton (1965) proposed a simplification by suggesting that all strategies could be classified as either a power type, or an attitude type strategy. Basically, a strategy of the power type would involve an overstating of one's aims, simultaneously stressing differences between the two groups involved. This would require a capacity to coerce and to control information, creating ambiguity for the other group. A strategy of the attitude type would involve an attempt to minimize differences, stressing trust, and seeking to provide openness and honest communication. An outstanding example of the use of pure power strategy is Saul Alinsky and his organization (e.g. Alinsky, 1946), and student activist efforts of the 1960's (Skolnick, 1969). Hansen (1967) appears to be in agreement with this simplification, but emphasizes the need for purposes and policies of the organization seeking change to be clear and consistent:

> If change is to have any real thrust, it must have both force and direction. That is, the change must come out of the constellation of forces that necessitate or demand change, but it must be given the direction that only clear-cut goals can provide. (p. 28)

but also points out that it is "... with the people and not the organization itself that we must concern ourselves ..." (p. 24).

Three models for change were suggested by Jack Rothman (1968) in a discussion of community organization practice. These he calls:

Locality development (Let's all get together and talk this over),
Social Planning (Let's get the facts and take the logical next steps), and
Social Action (Let's organize and destroy our oppressor).

Community development as generally conceived can be placed under his Locality Development model, though this traditional conceptualization is now dated and becoming outmoded in its exclusive emphasis on process goals. Mention must be made here also of Rothman's (1974) extensive treatment of studies on diffusion as a direct outgrowth of Everett Roger's (1962) groundbreaking formulations and scholarly contribution in reviewing more than 500 publications on the diffusion and adoption of innovations, and collating the findings into a consistent theoretical framework. Though not directly aimed at community planning and development, this work is closely related to such concern.

Roland Warren (1971) attempted a broader classification derived from a consideration of issue situations in the community. He described three such situations with a corresponding strategy for change:

(1) Issue consensus, where the change agent is confident of substantial agreement being achieved. In this situation he would employ strategies based on consensus decision, acting as an enabler or catalyst. Such strategies are described by Warren as collaborative strategies. Here the assumption is that there exists a common basis of values and interests.

(2) Issue difference, where the change agent does not have agreement, but expects to get it with minor effort. In this situation he would employ strategies based on persuasion - campaign strategies out of which consensus strategies for decision-making can be projected for the future. Warren suggests (p. 26) that community development is a campaign strategy.

(3) Issue dissensus, where the change agent does not have agreement among the principal parties involved, and cannot get this, or expect to achieve it. In this situation he will employ

strategies based on contest, though not necessarily conflict - contest strategies, in which "... one must pursue one's own goal in opposition to others, if it is to be pursued at all ..." (p. 22).

From a Canadian source can be mentioned the classification by Vrooman (1972), who suggested five strategies. As the title of his article suggests, he concerns himself not so much with social change in general as with citizen participation and the central role of power in decision-making within each strategy. His five strategies can be seen subsumed as sub-strategies under the broader developmental approach strategy suggested by Powell and Benne (1960). The five strategies are:

(1) the community therapy approach, aimed at developing cooperation in problem-solving, and to foster a "we" feeling among community members,

(2) social action approach, similar to Rothman's social action, suggests that community agencies may have a negative effect on community members, and seeks to alter such agencies and services,

(3) the information-communication-education approach, using information and reasoned argument for change,

(4) the advisory-consultative approach, involving community members directly on citizen-advisory committees in social planning providing advice and consultation to decision-making bureaucracies, and

(5) the delegated and community control approach, in which groups of community members receive decision-making authority from

government.

Kurt E. Olmosk (1972) noticed a consistency in strategies utilized by a group or by individuals over time. He describes an approach that he calls the Fellowship strategy, which is mainly used by churches, volunteer organizations, and groups with limited power. In addition to this strategy, he describes seven "pure" strategies. Olmosk points out though, that these are seldom used as pure approaches. Most frequently one strategy predominates, but is modified by one or more of the other approaches. At the end of his article, he provides a table summarizing and clearly setting out underlying assumptions of each approach or strategy.

Many other sources concerned with strategies for change can be found through a more intensive search from within practically any field of human endeavour. Some of these will be concerned with change in general, whilst some will deal with change under very specific and delimited situations and conditions. In general, there appears to be a trend for the strategies utilized to be in the process of moving from being responsive to crises to anticipating crises; from being controlled under a standardized administration to an innovative administration; and from dealing with specific measures to being aimed at comprehensive measures. This is highly desirable as far as the problem at hand is concerned. Especially a move from the rehabilitative approach to a more educative, and preventive approach is desirable. Strategies as applied to the present problem must be target oriented, and part of an overall approach to deliberately shaping or designing a culture for the future of man. For this it will be valuable to look to behavioral approaches, to the utilization of an "operant philosophy" in the service of preventive intervention in the community. There is an initial need for tactics to effect and facilitate a transition from custodial care to community care, but for efficient long-range community development, a strategy of primary prevention becomes essential. Thus if it is at all possible to ascribe a strategy specifically to community development, it must be a preventive one. In fact primary prevention is the community development strategy par excellence. A later section in this study will address itself to the question of primary prevention as a community approach to the problem of mental illness.

CHAPTER III

THE PROBLEM AND ITS SETTING

This study was based on the assumption that from a community development perspective the present trend to transfer the mentally ill from traditional, institutionalized, custodial care to community care is a positive and desirable move. Not only would such a move be directly beneficial to the patients, given the existence or establishing of appropriate facilities for care, but it is hoped that it may stimulate members of the community to reconsider such questions as:

"How can we more effectively meet our responsibility to our mentally ill and their families?", and

"How do we increase the successful social (community) functioning of a person, utilizing community resources, and thus preventing mental illness?".

Further it was thought that such a move of the responsibility for its own mentally ill back into the community could be an opportunity and a challenge for strengthening the psychological sense of community among members of the general public. It was hoped that the problem would initially give rise to a consideration of the process of community development as a primary preventive intervention, and give encouragement to a later implementation of such an intervention.

For the community development agent it is important to encourage and facilitate such a move. In order to enable him properly to plan with the community for a future "healthy" community, the present state of the community with regard to the question of mental illness must be assessed.

As a preliminary step in preparation for a preventive community development intervention this study attempted to:

(1) present a background information for the understanding of what can be accepted as a community, and a consideration of what man today perceives as mental illness,

(2) seek the opinions and attitudes of community members concerning mental illness. This was done in order to gain information concerning the present view of the community regarding a variety of issues related to the question of mental illness. A knowledge of the prevailing level of opinions and attitudes of community members would carry implications also for the question of the epidemiology of mental illness. It is the people of the community who decide what is to be considered deviant behavior, and who must be thought in need of treatment. Kessel (1963) dealt with this issue in an article entitled:

"Who ought to see a psychiatrist?", and Forrest (1967) raised questions of similar concern in his article: "Can we afford mental health?". Further it must be considered prudent and necessary to try to assess existing levels of attitudes and knowledge of the community members before embarking on a long-range community development intervention.

(3) investigate the possibility and implication of a relationship between the preferred model of mental illness, and preferred modes of referral, as held by members of the community. The immediate success of the contemplated move, and any lasting acceptance of a preventive community development intervention is dependent on the ideological position of the public, i.e. how the community members perceive mental illness, and which kinds of referral or approaches to deal with deviant behavior are preferred by them. The direction of such a relationship has implications for amount of preparatory effort needed within the community prior to the planned intervention.

(4) investigate alternative options of mental health resources available to members of the community, as they perceive it, in order to obtain an expression by involved members of the community of a felt need in this area.

(5) review examples of currently utilized strategies for change,

and to suggest community development strategies for participation and involvement, which could facilitate and make successful the move from custodial care to community care, and finally

(6) offer comments and suggestions for seeing primary prevention as the outstanding community development strategy.

The study was performed within the urban community setting, as it was thought the problems and issues relating to mental illness would be found more pronounced and more obvious against an urban rather than a rural setting.

Delimitations

The study did not attempt to predict cost of a move from hospital care to community care, as this obviously must depend on the type of community, available community resources etc., in each individual case. Some discussion of cost factors have been presented during the review of related literature in chapter II of this study.

. Further, the study did not seek to evaluate existing alternative health resources, nor attempt to estimate exact needs arising for a given population unit, being concerned mainly with a preliminary exploration and search for promising community development strategy, suitable for preventive community intervention approaches to the problem of mental illness.

CHAPTER IV

OBJECTIVES AND RATIONALE

There is now a trend within the mental health field to move the mentally ill from the traditional, custodial care to a more therapeutic community care. It is generally believed that such a move will be desirable. It is seen as beneficial to the patients, and may stimulate greater integration of the community.

The community is responsible for its own members, and for providing supportive resources. Members of the community seek to develop the potentials for coping successfully with hazards and stresses naturally occurring in the community. A move of the mentally ill back into the community, and an attempt at retaining within the community such members as may be suffering from emotional and behavior disorders, presents hazards and stresses to the community. Equally hazardous and stressful may be a more explicit emphasis on primary prevention.

This study was prompted by a realization of the importance to community development of such impending changes. The contemplated move and change in emphasis was thought a challenge and an opportunity for the community development agent. It was seen as a stimulus for intervention. The community development agent in facilitating such a move might utilize this opportunity and challenge in his efforts to achieve the goals of community development:

(a) to develop and strengthen a psychological sense of community,

(b) to promote the well-being of all members of the community, and

(c) to develop all community resources in aid of primary preventive approaches.

Thus the primary objective of the study was to assess the community members' views on mental health issues in order to indicate which efforts on the part of the community development agent would be needed, could be successful, and how he could utilize the issue of mental health and change toward community care away from custodial care for the purpose of strengthening and developing a psychological sense of community.

Comments and suggestions were made for primary prevention seen as being the community development strategy par excellence, thus indicating the very important and real role of community development in matters of mental health and illness.

For the community development agent it was, therefore, considered essential to obtain a reasonably clear impression (knowledge) of the present state of the community with regard to issues in mental health and illness in preparation for the planning and implementation of community development interventions.

Therefore, in this study, it was sought to:

(a) present a theoretical discussion and analysis of what can be accepted as community, as background information for an understanding of the field, within which the community development agent must seek to introduce primary preventive interventions,

(b) present a historical, theoretical discussion and analysis of how man through history up to the present has perceived mental illness and its causes. This was thought to provide background knowledge for comparison with the viewpoint of todays community member on issues in the mental health field. Such knowledge was considered necessary for the community development agent to enable him to decide on required and most efficiently effective interventions,

(c) seek the opinions and attitutdes of community members concerning mental illness in order to gain information concerning the present view of the community with regard to a variety of issues related to the question of mental illness. This was done by presenting three instruments to members of the community, i.e. the Baker-Schulberg Community Mental Health Ideology scale (CMHI), the Maclean Opinion and Attitude Statements scale, and the Mode of Referral questionnaire (MOR). It was considered prudent and necessary to assess existing levels of opinions and attitudes of community members prior to embarking on a long-range community development intervention.

The Baker-Schulberg Mental Health Ideology Scale:

As community care is extensively dependent on the mental health ideology to which members of the community subscribe, a knowledge of the dominant ideology in the community becomes important to the community development agent.

Werner Stark (1958) pointed out that all forms of thought are socially conditioned in the very nature of things. It can, therefore, reasonably be assumed that not only professionals but laymen of the general public as well, order their response to a variety of issues on the basis of an underlying ideology. Baker and Schulberg (1967) and Baker (1974) suggested the existence of a community mental health ideology and provided an instrument for measuring adherence to this ideology.

An ideology can be seen as a map of problematic social reality which serves to foster the creation of collective conscience (Geertz, 1964).

It has the power to knot a social group together and creates strong integration and solidarity.

For the community development agent, who is concerned with establishing an integration and solidarity, a psychological sense of community, knowledge of what strength of adherence to a community oriented ideology exists among members of the community becomes essential. As the ideology plays a role in strengthening social consensus, defining social categories, relieving social tensions and stabilizing social expectations (Geertz, 1964), the kinds of intervention the community development agent will attempt depend on the kind of assumptions the community members make about issues in mental health.

The Baker-Schulberg scale appeared to be the one available best differentiating between adherents of a custodial ideology and adherents of a more liberal community approach ideology. It has been widely used with various groups of mental health professionals. It appears that such study of underlying ideology as accepted by the general public has not been done. It is, however, the ideological stand of the community members which perhaps is the main factor to consider in any mental health/illness issue. Thus the use of the CMHI scale was extended in this study, possibly for the first time, to the general public in the community.

Results derived from the scale would suggest how close the community is to accept a community care ideology. This has importance and implications for indicating level of community preparedness for a move of the mentally ill and for community development preventive interventions.

The Maclean Opinion and Attitude Statements scale:

The scale derives from a study in Edinburgh in 1966 (Maclean, 1969). It was selected for use in this study because it appeared to provide in an unobtrusive form the opportunity to extract several subscales of particular interest in the present consideration of mental health/illness issues in the community. Indications of the way in which the members of the community think in relation to various topics of the subscales were seen as constituting essential knowledge for the community development agent. Before he would decide on approaches and interventions which could be accepted as desirable and practicable by the community, some knowledge of the existing level of opinions and attitudes of community members would seem to be a necessary prerequisite. Results from the use of the scales would provide answers to several questions of importance to a successful community development effort, as will be indicated later in this chapter.

The Mode of Referral questionnaire:

The instrument was developed by offering ten descriptions of persons suffering from emotional and/or behavior disorder. Six of these were the same as previously utilized by Cumming and Cumming (1957). Two descriptions originated from Kisker (1964), one from Suinn (1970), and one from the writer's professional experience. Following each description are a series of questions pertaining to the respondents' perception of mental illness, and preferred mode of referral. This instrument was utilized in order to provide the community development agent with information of what the community member sees as mental illness, what kind of person he would think in need of treatment, and which preferences exists with regard to mode of referral. How the community member utilizes existing mental health resources would be indicated, and has importance for choice of intervention.

Finally the questionnaire provided information through two open-ended questions, and space for comments and suggestions about the community member's knowledge of available facilities and alternative options of mental health resources in the community as perceived by its members. This was thought to provide the community development agent with knowledge of existing level of awareness and felt needs in the community - of obvious importance prior to extensive and long-range planning. No community development intervention should be planned or undertaken without first having arrived at an indication of felt needs in the community.

(d) present a theoretical review of currently utilized strategies for change, and to suggest community development strategies for participation and involvement, which could facilitate and make successful the move from custodial to community care for the mentally ill, and prepare the community members for future preventive approaches. Such strategies and intervention approaches would be derived from a consideration of the expressed attitudes and opinions of the community members through responses to the three instruments utilized in this study.

(e) offer comments and suggestions for seeing primary prevention as the outstanding community development strategy. This was done in a final chapter through a theoretical consideration of the concept of prevention.

The study attempted to seek and provide information with regard to various hypotheses, and answers to questions as indicated in the following section:

Hypothesis 1: There exists a significant relationship between the ideology of mental illness preferred by the member of the community and his preferred mode of referral.

Information for this hypothesis was sought in the obtained scores on the CMHI scale and in their correlation with modes of referral as indicated in the MOR questionnaire.

Hypothesis 2: The present alternative options of mental health resources as perceived by the community members, are inadequate to meet requirements arising from the move of the mentally ill from custodial to community care - and insufficiently known to members of the community.

Information for this hypothesis was sought in the responses offered by community members to the open-ended questions of the MOR questionnaire as compared to listings of actually existing mental health resources in the community.

Hypothesis 3: The community members are largely accepting of a community mental health view, and to a significant extent dissatisfied with the present attitude to the mentally ill.

Information for this hypothesis was sought in the obtained scores on the CMHI scale, and from the responses to statement 42 of the Maclean scale.

Hypothesis 4: The majority of community members are rejcting the mentally ill when their disorder is seen as an exaggerated deviation, but accepting toward the mentally ill whose behavior is perceived as less exaggeratedly deviating, i.e. the general public does not easily recognize cues for mental illness.

Information for this hypothesis was sought in scores obtained on the Social Distance subscale of the Maclean scale, and from an examination of responses to the descriptions of different types of deviance presented in the MOR questionnaire.

Hypothesis 5: In spite of attempted mental health education over a long period of time, members of the community still view the mentally ill as violent and dangerous.

Information for this hypothesis was sought in the subscale: Potential danger of the mentally ill, of the Maclean scale.

Further the study was thought to suggest answers to questions, such as the following:

Illness and treatment:

What type of deviance does todays community member perceive as mental illness?

Responses to the MOR questionnaire, and especially to the question: "Would you say this person has some kind of mental illness?" provided the answer to this question.

> What does the community member see as mental illness, and which factors and variables as found in this study are grouped together with such a view?

This question was answered from the MOR questionnaire and from significant correlations to other factors as examined in this study.

> Who in the opinion of community members are in need of treatment?

Again the MOR questionnaire provided the answer. The question: "Do you think this person is in need of some kind of treatment?" for each of the ten descriptions indicated reasonably clearly the view held by members of the community.

> Which type of treatment approach is perceived as being most effective?

In addition to referrals as indicated for each of the ten descriptions of the MOR questionnaire, responses to the Maclean scale's questions 2, 7, 16, 25, and 30 provided some indication of the community members' perception of this issue.

Causation of mental illness:

If the real problem is in the definition of mental illness how does the community member see or define this?

Responses to the MOR questionnaire, and indications derived from the CMHI scale provided some insight into this question.

Does the community member see emotional/behavioral disorder (mental illness) as a result of intrapsychic processes or of external, environmental situations?

Answer to this question came from a content analysis of the CMHI scale and from the Maclean subscale: Perceived causation of mental illness.

Ideology:

Which mental health ideology is accepted by the majority of the community members?

Answer to this question was most directly seen from the CMHI scale scores, but also from content analysis of this scale. Further indication was also obtained from the Maclean subscale: View of hospital committal and its consequences. Further supporting evidence was derived from interpretation of Maclean subscales: Social Distance, and Perceived public tolerance of the mentally ill.

What is the likelihood of consensus in the community with reference to mental health issues? Could the community members' ideological stand become activated to the point where pressure groups could be established in favor of a community care ideology?

Answer to this question was derived from an interpretation of the return rate of the mailing of the three instruments to the community members, and from comments and suggestions on the returns.

Mode of Referral:

What is presently the preferred mode of referral?

The question was answered by listing utilization of mental health resources indicated in the MOR questionnaire.

Does the community member react significantly different to the male and to the female disturbed person?

Evidence for this was sought in correlations between variables examined in this study, and especially from a comparison between the responses obtained to descriptions of anxiety neurosis in a male and in a female person. Some indication was derived too from an analysis of responses to the question whether the described disturbance was seen as mild, moderate, or severe.

Community responsibility:

What today is the attitude toward mental illness and the mentally ill, and what is the level of interest in mental health issues in the community?

Answers were sought in a consideration of return rate for the three instruments. Similarly, scores on the CMHI scale, the Maclean subscales: Social distance, and Public tolerance, as well as responses to the Maclean scale statements 5, and 13 gave some indications for the answer.

Is the community now more ready and willing to accept community care of the mentally ill as compared to results indicated in other previous studies (e.g. Nunnally, 1961; Cumming and Cumming, 1957)?

This question was clarified through as direct a comparison of findings as the data would allow for on the main issues. Some indications were obtained also from comments and suggestions on the returned instruments.

Facilities and resources:

Are existing alternative options of mental health resources (facilities) sufficiently known to members of the community?

This was answered by comments on the MOR questionnaire, and responses to the open-ended questions on same.

> Do the community members have a clear idea of which mental health facilities and resources may be needed? Is there from the community a clearly expressed 'felt need'?

Responses to the open-ended questions, and comments and suggestions from the MOR questionnaire provided some indication of the level of this issue in the community.

In addition to answers and indications obtained from the directly relevant sections of the three instruments, all hypotheses and questions were considered with the aid of obtained significant correlations from within the main correlation matrix.

CHAPTER V

STATEMENT OF DESIGN AND HYPOTHESES

The design utilized for this study was a cross-sectional, analytical survey method. This method was chosen as it was desired to collect data at one point in time describing the community population at that time with regard to the problems as previously presented, as well as seeking to determine relationships between variables at the time of the study. The problem was seen as lending itself best to this technique of observation with some statistical analysis of collected data.

Hypotheses

A total of five hypotheses were suggested, whilst several questions were aimed at other aspects of the study.

(1) There exists a significant relationship between the ideology of mental illness preferred by the member of the community and his preferred mode of referral.

(2) The present alternative options of mental health resources as perceived by the community members, are inadequate to meet requirements arising from the move of the mentally ill from custodial to community care - and insufficiently known to members of the community.

(3) The community members are largely accepting of a community mental health view, and to a significant extent dissatisfied with the present attitude to the mentally ill.

(4) The majority of community members are rejecting the mentally ill when their disorder is seen as an exaggerated deviation, but accepting toward the mentally ill whose behavir is perceived as less exaggeratedly deviating; i.e. the general public does not easily recognize cues for mental illness.

(5) In spite of attempted mental health education over a long period of time, members of the community still view the mentally ill as violent and dangerous.

CHAPTER VI

METHOD AND PROCEDURE

Data

The data of this study are of two kinds: primary data, and secondary data.

The primary data are of two types. The first type consists of responses to three questionnaires: the Baker-Schulberg community mental health ideology scale, the Maclean opinion and attitude statements scale, and the Mode of referral questionnaire. The second type consists of responses to eight demographic variables.

The secondary data are derived from published studies dealing with the change from institutionalized care to community care for the mentally ill, models of mental illness, and questions of prevention.

Subjects

The subjects of this study were 300 individuals, selected by systematic random selection from the Edmonton Telephone Directory, 1977, and 100 individuals selected similarly from the Wetaskiwin Telephone Directory, 1977. All subjects were adults of both sexes.

Instruments

Three instruments were utilized as follows:

(1) The Baker-Schulberg Community Mental Health Ideology Scale (CMHI)

Baker (1974) has defined ideology as being a commonly adhered to system of ideas and beliefs which serve to justify the position of a group, and which acts as a rationale for its behavior. Accepting this definition, it can reasonably be assumed that not only professionals, but also laymen order their response to a variety of issues on the basis of an underlying ideology. When considering community mental health and the general public's response to questions of mental illness, it therefore appears useful to seek knowledge regarding the ideology acceptable to the majority of community members. This is particularly the case when a change in existing approaches to the treatment of mental illness is planned. For the community development agent a knowledge of the prevailing ideology must be considered essential prior to any attempt at preventive community development interventions.

As Geertz (1964) state, the function of an ideology is to render incomprehensible social situations meaningful, to so construe them as to make it possible to act purposefully within them. For the community member without professional training, the social situation of mental illness may at times seem incomprehensible. In order to protect himself and deal successfully with such a situation, he will readily lean upon a dominant ideology. As Marx (1969) has pointed out, this will enable him to take purposeful action in the face of uncertainty. The desirability of the outcome of such action depends on which ideology the person prefers. All ideologies are evaluative in that they contain statements as to what ought to be, regardless of what actually exists. Thus the approach, or mode of referral, to the treatment of what community members perceive as being mental illness is importantly a reflection of the members' preferred ideology. Nor is the professional excluded from being dependent on a preferred ideology (Armor and Klerman, 1968).

A move towards community care will be most successfully achieved the more strongly the community mental health ideology is accepted. It was, therefore, decided to utilize this instrument in the present study. As far as a review of the literature indicated, the CMHI scale has never before been utilized with members of the community in general. This study, therefore, has extended the use of this scale to the general public in the community, possibly for the first time.

The scale consists of thirtyeight items. Half of these are favoring a community mental health ideology, and half are unfavorable to this ideology. Reversed scoring is used for the negatively worded items. Thus the higher the score is on the scale, the more that subject is in agreement with the basic principles of the community mental health ideology. Baker and Schulberg (1967) describe the development, validity, and reliability of the scale. The reliability is given as .94 for the Cronbach Alpha (generalized Kuder-Richardson formula 20), and the split-half reliability as .95 (odd-even corrected by Spearman-Brown formula) for the total group of 484 mental health specialists used as respondents for the first version of the CMHI scale.

The scale has been used to measure degree of adherence to the principles of community mental health, and was developed on psychiatrists, psychologists, and occupational therapists. It was not extended for use with the general public.

In a study (Baker and Schulberg, 1969), the authors compared their scale to Rokeach's (1960) dogmatism scale, and to a five-item form of the Political-Economic Conservatism (PEC) scale (Adorno et al., 1950). Rokeach's scale was designed to measure the general personality trait related to one's ability to form new conceptual systems, and thus can be thought to have importance for one's ability to change toward greater acceptance of community mental health principles. The Pec scale indicates that the dimension of liberalism versus conservatism is integral to the assessment of the authoritarian personality. The findings of the study were that correlation between dogmatism and political-economic conservatism was .66. The greater adherence to community mental health ideology correlated negatively with dogmatism ($r = -.38$, $p < .01$), and negatively with political-economic conservatism ($r = -.40$, $p < .01$).

An attempt at expanding and repeating the Baker and Schulberg (1967) study was made by R. F. Langston (1970). He utilized staff available at two community mental health centers. His results were in agreement with those of Baker and Schulberg. It was found that a positive correlation existed between a liberal arts education and CMHI scale scores ($r = +.50$), and between CMHI scale scores and length of time the professional had been involved in community mental health work at the center ($r = +.53$, $p < .01$). Contrary to Baker and Schulberg, Langston did not find any relationship between age and CMHI scale scores. Poovathumkal (1973) studying paraprofessionals from five different community mental health centers in Chicago found that neither practical experience, not age had any significant influence on the scores. Other studies have been concerned with nursing staff (e.g. Howard and Baker, 1971), with comparison between executive staff, treatment staff, and summer student aides (e.g. Block, 1974), and with comparison between rural and urban community health center staff (e.g. Wagenfeld et al., 1974). Wagenfeld and coworkers found that adherence to CMHI was stronger in centers servicing all rural areas as opposed to inner city urban, and suburban centers, or areas.

Of importance with reference to a community mental health ideology when considering the community development agent himself, and possible choices of indigenous workers in a preventive community development intervention are few studies that concern themselves with personal style of program implementors. Thus for example Mehr (1973) found that successful program implementors were able to live with complexity, whilst unsuccessful ones were found to have a tendency to oversimplify reality. He also found clinical knowledge less important than characteristics of initiative, willingness to accept responsibility, calculated risk-taking, and a commitment to involvement. Hirschowitz (1971), and Morrison et al. (1973) similarly stressed the need for role flexibility when working in a community setting.

Baker and Schulberg (1967) found that the younger person was more in favor of a CMHI than the older person, possibly due to a lack of emphasis on formal structure and role delineation for the younger person. A low score on the CMHI scale can be expected from the community members in general, as they tend to support the medical model, secondary prevention, and the importance of psychiatrists (Rabkin, 1972; 1974). Such a finding will have implications for the advocating of extensive community control of mental health programs. This can be done successfully only if there is a willingness amongst members of the community to move away from the medical model and accept a CMHI in greater measure, Physicians, the general practitioners, also score very low on the CMHI scale (Baker and Schulberg, 1967; Block 1974; Perkins and Thompson, 1974). According to statements by Farnsworth (1968), Bandler (1968), and Williams and Ozarin (1968), this results most likely from a lack of willingness to give psychological problems similar attention as given to physical illness.

In a study commissioned by the Provincial Government of Alberta (Alberta Health and Social Development, 1974) it was found from a random sample of 1000 members of the general public that 58 per cent of these refer to a general practitioner when faced with an emotional problem. In this study also the public scored low on complexity suggesting that it perceived the environment, or reality, in a simplifying manner. This could make the general public reluctant to utilize available community resources, and less likely to feel a need for alternative options of community resources contrasted with the traditional, institutionalized facilities. Add to this the physicians' low score on the CMHI scale, and it is unlikely that they will advise community members, referring them to utilize the community mental health model.

Finally it can be mentioned that Perkins and Thompson (1974) used a modified CMHI scale with only eleven items. More research on this adaptation is needed to establish its validity and reliability.

(2) The Maclean Opinion and Attitude Statements questionnaire.

The questionnaire derives from a study in Edinburgh in 1966. The instrument was developed by the use of statements culled from various sources (Star, 1950; Nunnally, 1961; and Belson, 1957 a), and was described in its final form by Maclean (1969). It included variables, e.g. demographic, and the twelve-item form of the Maudsley Personality Inventory (Eysenck, 1958), a measure of respondent's regard for what Phillips (1965) had called the "norm of self-reliance", measures of personal experience of mental illness, and of information obtained through the mass-media, and a final section on personal suggestions for how to avoid mental illness. The central portion consisted of the fortyseven statements utilized in this study. The author compares findings from the administration of the instrument with the results obtained in 1956 by Belson in a London survey of BBC audiences (Belson, 1957 b).

Various subscales are derived from the statements by grouping them within related groups, thus:

(1) The potential danger of the mentally ill -
Statements: 1, 12, and 41

(2) Views of hospital committal and its consequences -
Statements: 2, 7, 9, 29, 32, 33, and 43

(3) Explicit sympathy for the mentally ill,
Statements: 3, and 14

(4) The contagion of mental illness,
Statement: 4

(5) Social acceptability of the ex-patient (Social Distance),
Statements: 6, 11, 15, 34, 37, 40, and 45

(6) Perceived causes of mental illness,
Statements: 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28,
44, and 46

(7) Perceived public tolerance,
Statement: 42

(8) Personal dread of mental illness,
Statement: 31

(9) Personal characteristics of the mentally ill,
Statements: 8, 10, 35, 36, 38, and 39

Results from the Edinburgh study and the London study will be compared with findings of this present study in chapter VII.

(3) The Modes of Referral questionnaire.

The instrument consists of a series of ten descriptions of various persons in the community, each suffering from mild to severe emotional and behavioral problems. Following each description are a series of questions pertaining to the respondents' perception of mental illness, and preferred mode of referral.

Six descriptions (A-F) are taken from the ones developed by Dr. Star, and utilized by Cumming and Cumming(1957). It will, therefore, be possible to make comparisons betweeen results obtained in previous studies and findings of the present study. One description (G) originates from Suinn (1970). Two descriptions (H, I) originate from Kisker (1964), and one final description (K) is derived from the writer's professional experience.

The emotional and/or behavioral problems associated with each description is as follows:

A.	Paranoid Schizophrenia	(male)	
B.	Simple Schizophrenia	(female)	
C.	Anxiety Neurosis	(male)	
D.	Alcoholism	(male)	
E.	Compulsive phobic Neurosis	(female)	
F.	Juvenile Character Disorder	(male)	
G.	Anxiety Neurosis	(female)	Suinn (1970), p. 230
H.	Exhibitionism	(male)	Kisker (1964), p. 234
I.	Neurotic Depression	(female)	Kisker (1964), p. 292
K.	Drug Dependency	(male)	from writer's experience

The questionnaire ends with questions seeking the community member's knowledge of available facilities for dealing with individuals having problems as indicated in the ten descriptions, as well as giving the respondent an opportunity to express a need as perceived by him for other facilities in the community.

Procedure

A total of 300 subjects from the Edmonton Telephone Directory, 1977, and a total of 100 subjects from the Wetaskiwin Telephone Directory, 1977, were selected, using the following procedure: Following a random start, a selection interval, I, was applied to the list of names of subjects from the telephone directory, so that every Ith subject in the list was included in the sample. The interval was determined by dividing the population size (estimated no. of entries in telephone list), N, by the sample size desired, n. The random start was found by selecting a number at random from within the first interval, using a table of random units (Selby, 1973, pp. 629 - 632). Remaining subjects were selected by adding the value of the interval to the random start number, and to the succeeding numbers obtained in this way. This systematic selection was preferred to simple random sampling because of greater convenience in selecting the sample. Further, this sampling provides stratifying from the telephone directory list, which is implicitly stratified alphabetically by surname of subjects.

Three instruments (Baker-Schulberg Community Mental Health Ideology scale, Maclean scale, and Modes of Referral questionnaire) as previously described (v. pp. 181 - 190), together with a personal information sheet, were mailed to the subject's home address. A covering letter, explaining the general purpose of the study, and asking the subjects to write, if they wished later to receive a summary of the results of the study was enclosed. With each letter, a self-addressed, stamped envelope for returning the completed questionnaires was also enclosed.

Fourteen days after the date of the initial mailing of the questionnaires, a telephone follow-up was made. During this initial follow-up, 92 (23 %) subjects were contacted, and requested to return the questionnaires. Ten days following the initial telephone follo-up, a second telephone follow-up was made to those not able to be contacted during the initial follow-up. A further 32 (8 %) subjects were reached in this follow-up. Telephone calls were made between the hours of 18.30 and 20.30 over three consecutive days in each follow-up. There was no noticeable increase in return of questionnaires following telephone follow-up.

After waiting five weeks, a total of fiftyone completed questionnaires were returned. Of all subjects returning the questionnaires, only 16 (31.4 %) requested a summary of the results.

Data Analysis

Responses on all questions (except two groups of six questions each on the Maclean scale) were entered unto computer cards. The two groups of questions from the Maclean scale did not lend themselves to combined scoring. One group concerning personal characteristics of the mentally ill is discussed separately in chapter VII (v. pp.223 - 227). The other group of six questions did not receive any discussion by Maclean (1969). Responses to these questions are listed in the Appendix.

The FOPPS MAIN 181 program of the Computer Services of the University of Alberta was used for statistical measures. Thus there were sixtyone variables in total for which intercorrelations (Pearson Product-Moment Correlation Coefficient) were obtained. The significant correlations have been tabulated (v. Appendix, pp.

Chi-square and t-tests were performed to test significance of difference between the following groups:

Chi-square test:

(1)	Edmonton/Wetaskiwin subjects	(return rate of questionnaire)
(2)	-	(Social Distance scale)
(3)	-	(View of hospital committal and its consequences)

(4) Edmonton/Wetaskiwin subjects (Perceived public tolerance of the mentally ill)

(5) - (Personal dread of mental illness)

(6) - (Perceived causes of mental illness)

(7) - (The contagion of mental illness)

(8) - (Explicit sympathy for the mentally ill)

(9) - (Response rate to "Comments and Suggestions" of the MOR)

(10) - (Potential danger of the mentally ill)

(11) Male/Female scoring on the CMHI scale

(12) Description C/Description G of the MOR questionnaire (Responses to four questions):

a. Would you say there is anything wrong with this person?

b. Would you say this person has some kind of mental illness?

c. Do you think this is a mild, moderate, or severe disturbance?

d. Do you think this person is in need of some kind of treatment?

t-test:

(1) Interpair differences of mean scores on the CMHI scale for age groups I - V (v. Table 6).

CHAPTER VII

RESULTS

A total of 400 questionnaires were mailed out to community members in two urban areas, the cities of Edmonton and of Wetaskiwin in the province of Alberta:

		mailed	returned
Edmonton	(approximate population: 500,000)	300	33 (11 %)
Wetaskiwin	(approximate population: 10,000)	100	18 (18 %)
	Total:	400	51 (12.75 %)

It was thought that a significant difference in response rate could exist between a large metropolis and a smaller urban center. A chi-square test (chi-square = 3.31) performed on the data, indicated, however, that there was no significant difference between the return rates from the two cities.

Age of fortyeight respondents ranged from 20 to 75 years, with a mean age of 40.06 years. Three respondents did not indicate their age. As far as age is concerned the demographic characteristics of this sample conforms fairly close to the known parameters of the total Alberta population when compared to the findings of the Alberta 1971 census, and findings of the Alberta Health and Social Development (1974) study:

Table 1

COMPARISON OF AGE GROUP DISTRIBUTION IN VARIOUS SOURCES

Age group	Alta. 1971 Census	This study	Alta. Health & Soc. Dev.
18 - 24 years	20.4 %	16.7 %	14.5 %
25 - 34 years	21.8 %	35.4 %	25.5 %
35 - 49 years	28.0 %	16.7 %	30.0 %
50 - 64 years	19.0 %	18.8 %	18.6 %
65 years +	11.0 %	12.5 %	10.6 %

As can be seen in this study, there is a slight undersampling in the 18 - 24 year group, and in the 35 - 49 year group. Oversampling is indicated in the 25 - 34 year group.

Such slight deviances can be caused by various factors. Thus, the present sample was small, and the respondents' return rate was low. Again, mail was addressed to respondents listed in telephone directories, which probably would account for undersampling in the 18 - 24 year group, and oversampling in the 25 - 34 year group. Mailing was done in the beginning of the traditional holiday season. Possibly some heads of families in the 35 - 49 year age group, likely to have school-age children may have been absent on holiday. Again the small sample and low response rate may partly account for the result.

Of the 51 subjects responding, 35 (68.63 %) were male; 15 (29.41 %) were female. One subject did not indicate sex. The majority of the respondents were married (60.78 %), with approximately one quarter sincle (25.49 %). One respondent did not indicate marital status.

47 respondents indicated years of schooling received. 57.45 % indicated that they had received some college education or education beyond college level (23.40 %). Remaining 42.55 % indicated education at High school level or less.

Three respondents did not incicate their income group. Of the 48 respondents who did, approximately one-third (31.25 %) were found to be earning below the average income for Canadians as indicated by Statistics Canada (1977) with less than $ 12,898.60 per annum. Approximately two-thirds (62.50 %) were found to be earning $ 14,000.00 or more per annum.

The present study proposed several hypotheses, and posed various questions. The results of the study as applied to these were as follows;

Hypothesis 1:-

Fiftyone subjects answered the Baker-Schulberg Community Mental Health Ideology scale (CMHI), and obtained scores ranging from 100 to 257. Mean score was 184.90; standard deviation: 32.37. Distribution of the scores in the four quartiles were as follows:

Quartile I	Nil	CMHI scores:	38 - 95
Quartile II	9 (17.65 %)	CMHI scores:	96 - 152
Quartile III	30 (58.82 %)	CMHI scores:	153 - 209
Quartile IV	12 (25.53 %)	CMHI scores:	210 - 266

Thus 42 respondents (82.35 %) obtained CMHI scores in the upper two quartiles. Only for description E, Compulsive Phobic Neurosis, female, of the Mode of Referral questionnaire (MOR), was a statistically significant correlation found between obtained scores on the CMHI scale and preferred mode of referral (r = .3472). Correlations approaching five percent level of significance (r = .288) were found for description B, Simple Schizophrenia, female (r = .268); for description A, Paranoid Schizophrenia, male (r = .214); and for description G, Anxiety Neurosis, female (r = -.214).

The correlation values between the obtained CMHI scores and the Mode of Referral for the ten descriptions of persons suffering from "mental illness" can be seen from Table 2 (p. 198).

Table 2

CORRELATION VALUES CMHI SCORES/ MODE OF REFERRAL

Description	Disturbance	r
A	Paranoid Schizophrenia	.214
B	Simple Schizophrenia	.268
C	Anxiety Neurosis	.137
D	Alcoholism	.110
E	Compulsive Phobic Neurosis	.347
F	Juvenile Character Disorder	-.030
G	Anxiety Neurosis	-.214
H	Exhibitionism	.082
I	Neurotic Depression	.131
K	Drug Dependency	-.039

r at $p < .01 = .372$; r at $p < .05 = .288$

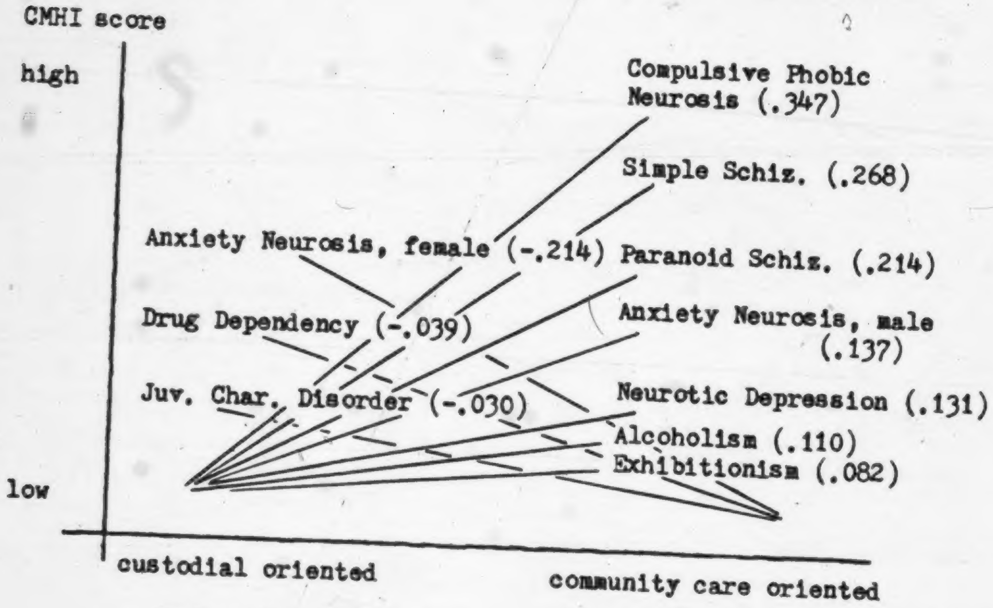
Though not reaching levels of significance, except for description E, Compulsive Phobic Neurosis in a female, the relationships can be seen graphically for the ten descriptions in Figure 1 (p. 199).

Though hypothesis 1 could not be definitely supported from this study, the general trend evidenced by the correlations

Figure 1

GRAPHIC PRESENTATION OF

CORRELATION VALUES CMHI SCORES / MODE OF REFERRAL



Referrals from the MOR questionnaire

as indicated in table 2, and figure 1 suggest the hypothesis could be verified had the sample been larger, and the referral options more clearly separated into a custodial oriented group, and a community care oriented group. More sophisticated research could possibly bring out this relationship more clearly than was possible in this exploratory study.

Hypothesis 2:

Out of 51 subjects responding to this study, 33 (64.71 %) answered the open-ended questions of the MOR questionnaire, or made some remark under the heading: Comments and Suggestions. Most of the answers and remarks were extremely scanty. The returns were distributed as follows:

Edmonton	- 20 (60.61 % of Edmonton respondents)
Wetaskiwin	- 13 (72.22 % of Wetaskiwin respondents)
Total	- 33 (64.71 % of total respondents)

A chi-square test was performed (chi-square = .69, df 1), which indicated that there was no significant difference in the rate of responding between the two groups.

Table 3 indicates the community members' awareness of, or knowledge of mental health resources and facilities presently available in the community. These are listed in Table 3 in order of frequency of response. All respondents mentioned one or more resources, which could be grouped together in the category, here mentioned as: Social Services.

Only one respondent mentioned the Community Psychiatric Nurse. As this mental health resource must be considered highly

Table 3

FACILITIES LISTED AS AVAILABLE BY COMMUNITY MEMBERS

Type of facility	Mentioned by no. of respondents
Social Services (i.e. AA, AADAC, Home Care Programs, PSS, Salvation Army, Soc. Workers, Sociologists, Welfare Dept.)	33
School and Guidance Clinics	12
General Hospitals	12
Family Doctor	11
Provincial Mental Hospital	10
Clergy	9
Private Psychiatrist	9
Local Health Unit	9
Police and Probation Officers	7
Community Mental Health Services	3
Family Services (Jewish, Catholic, etc.)	3
Crisis Center	2
Mentally Handicapped (retarded) institution	2
Community Psychiatric Nurse	1

important for a successful community care system, the visibility and the utilization of the community psychiatric nurse needs urgently to be increased. Generally the respondents appeared rather poorly informed concerning available resources and facilities.

A comparison of subjects' responses with listings of available facilities in such publications as for example, AID * a directory of community services for Edmonton and District, will support this conclusion.

Hypothesis 3:

The answer for this hypothesis was found from scores obtained by community members on the CMHI scale.

All subjects responded to this scale, and scores were ranging from 100 to 257 indicating a fairly heterogeneous group. The scale indicates strength of adherence to a community mental health ideology:

(1) a focus on the total population,

(2) prevention of mental illness through environmental intervention, and

(3) involvement of a variety of community resources in mental health issues.

---

* AID, Annual publication by Aid Service of Edmonton, 203, 10711 - 107 Avenue, Edmonton, Alberta.

The higher the obtained scale score, the stronger the adherence to a community mental health ideology.

Of the 51 subjects, 42 (82.35 %) obtained CMHI scores lying in the upper two quartiles, whereas only 9 (17.65 %) respondents were found to have obtained CMHI scores lying in the second quartile, and none in the lowest one.

This can be compared to CMHI scores in the literature (Baker and Schulberg, 1967; Block, 1974; Perkins and Thompson, 1974). Table 4 has been taken from Perkins and Thompson (1974) who used a modified form of the CMHI scale, consisting of only 11 items. They have converted the table given by Baker and Schulberg (1967) to make a direct comparison of scores possible. Results from the present study have been converted and added.

Though the present group scored low on the CMHI scale, as could be expected, the results indicate that the majority of community members (82.35 %) are accepting of a community mental health view.

A chi-square test for possible difference in scores obtained by female and male community members was calculated. The obtained chi-square (2.09; df = 1) indicated that no significant difference existed between these two groups with respect to

Table 4 *

CMHI SCORES IN THE LITERATURE
(WITH RESULT FROM PRESENT STUDY ADDED)

Group	N	Mean	SD	Range
Harvard Postdoctorals	57	6.31	.51	4.34 - 6.89
Harvard Visiting Faculty	15	6.17	.71	4.21 - 6.95
Community Psychologists	23	6.16	.39	5.13 - 6.95
Grad. Psych. Nursing Students	356	6.13	.49	3.95 - 7.00
Columbia Postdoctorals	25	5.84	.63	4.55 - 6.84
APA Clinical Psych. Div.	79	5.73	.58	4.18 - 6.79
Amer. Occup. Therapy Assoc.	35	5.47	.55	4.24 - 6.39
Society for Biol. Psychiatry	29	5.43	.87	3.45 - 6.79
Amer. Psychiat. Assoc.	175	5.24	.97	2.42 - 6.97
Amer. Psychoanal. Assoc.	46	5.12	.82	3.29 - 6.82
Citizen Mental Health Board Members	140	5.76	.70	4.10 - 6.90
Community members, present study	51	4.81	.85	2.65 - 6.76
County Physicians	32	4.16	1.11	2.09 - 6.18

* Source: Perkins and Thompson (1974)

obtained scores. Nevertheless, the obtained chi-square value was in the direction towards significance at the five per cent level (chi-square = 3.84). It is possible that a larger sample might have indicated a difference in male/female scoring on the CMHI scale, significant at least at the five per cent level.

The finding by Baker and Schulberg (1967) that the total score on the CMHI scale is related significantly to age of subjects, so that those supporting community mental health beliefs tend to be younger was examined.

Fortyeight respondents indicated their age. The distribution of age groups were as can be seen from table 5.

Table 5

AGE GROUPS AND MEAN CMHI SCORE

Group	Years	f	Mean CMHI score
I	18 - 24	8	185.38
II	25 - 34	17	187.94
III	35 - 49	8	198.88
IV	50 - 64	9	181.33
V	65 +	6	158.33

In order to determine the significance of any difference between the groups, t-tests were performed for all groups. The t-test of all interpair differences between the means of the five groups are presented in table 6.

Table 6

t-TESTS OF INTERPAIR DIFFERENCES OF MEAN SCORES FOR AGE GROUPS ON CMHI SCALE

Group	II	III	IV	V
I	0.217	0.842	0.214	2.179 *
II		0.829	0.452	2.434 *
III			0.849	2.507 *
IV				1.137

* $p < .05$

Thus the present study only partly confirms the findings of Baker and Schulberg (1967) with regard to age, though a larger sample might have supported their findings more clearly.

The second aspect of the hypothesis was answered through an analysis of responses to the Maclean questionnaire subscale: Perceived public tolerance of the mentally ill (Statement 42).

Approximately two-thirds of the respondents in this study did not think that people nowadays are sufficiently tolerant toward the mentally ill. From the subscale (statement 42) the following results were obtained:

	Low score	High score
Edmonton	9 (27.27 %)	24 (72.73 %)
Wetaskiwin	9 (50.00 %)	9 (50.00 %)
Total	18 (35.29 %)	33 (64.71 %)

Low score indicated a satisfaction with the existing situation; high score a dissatisfaction with the existing situation. A chi-square test was calculated (chi-square = 2.63; df = 1). Though the chi-square measure did not indicate any significance in the difference obtained in the scoring between the two cities, it is possible that a larger sample would have produced a value of chi-square significant at the five per cent level: (chi-square = 3.84).

Of those who indicated that they did not think people nowadays are sufficiently tolerant toward the mentally ill (i.e 32; 62.75 %) just over one-third (11; 34.38 %) did so strongly.

Thus the results support hypothesis three, that the majority of the community members are accepting of a community mental health view, and that they are in general dissatisfied with the existing level of public tolerance toward the mentally ill.

In contrast to these findings are those of Maclean (1969), who found sixty per cent of her sample satisfied with the existing level of tolerance. Maclean suggests that the apparent complacency could be a result of the subjects contrasting the then existing climate with that of earlier times.

Hypothesis 4:

It was necessary, in order to answer the hypothesis from the results, to examine several significant correlations found between scores on the Maclean subscale, social acceptability of the ex-mental patient (Social Distance), and other variables of the study. Thus significant correlations were found between scores on the Social Distance scale, and:

CMHI scores: r = -.5073, indicating as would be expected, that the more community-oriented the respondent, the more accepting he was of the mentally ill (i.e. a lower social distance score).

Potential danger of the mentally ill: r = -.5570, indicating that the more accepting of the mentally ill the respondent was, the less likely he was to see the mentally ill as being dangerous.

Severity of situation (for description A, and B): r = -.4003, and r = -.4107 respectively, thus suggesting that the greater the social distance is, the less the respondent sees the situation as that of a severe disturbance, at least for these two descriptions. This may indicate a lack of sensitivity to mental illness presentation, or it may be a form of denial.

Is anything wrong with this person? (for description B, and for descriptions F, and I): Thus for description B (r = .3856), and description I (r = .3643), the higher the community member scores on the Social Distance scale, the more he tends to see nothing wrong with the persons described in descriptions B, and I. Again, this may indicate a lack of sensitivity, or a form of denial. For description F (r = -.3100), however, the opposite holds, i.e. the higher the community member scores on the Social Distance scale, the more likely he is to see something wrong with the person described in description F (Juvenile Character Disorder).

Then: Is it a kind of mental illness? (for descriptions B, E, and G). Here it was seen that the higher the score was on the Social Distance scale, the more the community member was unable or unwilling to see the persons described in descriptions B (r = .3150), E (r = .5682), and G (r = .4049), as having a mental illness. This must be seen again as either lack of sensitivity or a form of denial.

Looking at the MOR questionnaire, it was found that in the cases of the male exhibitionist (description H), the male drug dependent (description K), and marginally for the male anxiety neurotic (description C), the respondents did not see the disturbance as a mental illness. This also was the case for the female compulsive phobic neurotic (description E), and the description of the male with a juvenile character disorder (description F). For the latter, however, the community member scoring high on the Social Distance scale tended increasingly to see something wrong with the person described. All persons in the ten descriptions were seen as being in need of some kind of treatment.

From this it is here suggested that the community members do tend to reject the mentally ill when their disorder is seen as an exaggerated deviation; that possibly the general public has some difficulty in recognizing cues for mental illness. Further, it can be speculated that there is a strong tendency in the community for denial of mental illness. The relation between denial and depersonalization as discussed by Weckowicz (1970) could in this context give rise to some important future research.

Hypothesis 5:

On the Maclean subscale: The potential danger of the mentally ill, 54.90 % of the respondents indicated that they still would see in the mentally ill a source of possible danger to the community.

The hypothesis is thus supported, and a comparison may be of some general interest:

Table 7

COMPARISON OF VIEWS ON POTENTIAL DANGER OF MENTALLY ILL

Sample	Statement	Percentages in agreement
Belson (1957 a)	You never know what they are planning and it may be harmful.	33
Maclean (1969)	The mentally ill are dangerous.	33
This study (1977)	The mentally ill are dangerous.	50.98

The present study appears to indicate that, in spite of much recent mental health education, more of an existing undertone of fear and uncertainty is present in the community than was the case in the previous studies.

Further, results were obtained pertaining to questions posed under the following seven headings:

(1) Illness and treatment
(2) Causation of mental illness
(3) Ideology
(4) Mode of referral

(5) Discrimination
(6) Community responsibility
(7) Facilities and resources

Illness and treatment

(a) What type of deviance does todays community member perceive as mental illness?

From the responses to the MOR questionnaire six of the presented descriptions were seen as being of persons suffering from mental illness. Three of these, A, D, and I, were seen as being severe disturbances. Only three were clearly seen as not suffering from mental illness, namely descriptions E, H, and K. One description (F) was marginally seen as not being that of a mental illness.

Description A: Paranoid Schizophrenia (male) - 96.08 per cent of respondents were in agreement that this was some kind of mental illness. One may notice that the description referred to violence. This was seen by 43.14 per cent of the respondents as a severe disturbance.

Description B: Simple Schizophrenia (female) - 78.43 per cent of respondents thought that this was some kind of mental illness. No doubt this example and the paranoid schizophrenic of description

A are the more familiar examples of what has long been considered as mental illness.

Description C: Anxiety Neurosis (male) - here the opinions were almost evenly divided, i.e. 47.06 per cent saw this as some kind of mental illness; 45.1 per cent did not see it this way, and 7.84 per cent has no answer to the question. 64.70 per cent were in agreement that this was a mild disturbance.

Description D: Alcoholism (male) - Only just over half of the respondents (52.94 %) were willing to see this person as suffering from some kind of mental illness. Nevertheless, one-third (33.33 %) of the respondents saw this as a severe disturbance, and just over one-third (37.25 %) thought of it as a moderate disturbance.

Description E: Compulsive Phobic Neurosis (female) - this was the one description about which there was most agreement that it was not some kind of mental illness. 62.75 per cent of the respondents did not see this as mental illness.

Description F: Juvenile Character Disorder (male) - there was some uncertainty among community members with regard to this description. Thus 45.1 per cent saw this as a mental illness, while 49.02 per cent did not agree with this. A few (5.88 %) had no answer to the question. This disturbance was seen by 41.18 per cent of respondents as a moderate disturbance.

Description G: Anxiety Neurosis (female) - in contrast to description C, anxiety neurosis in the male, there was no doubt for the community members that the anxiety neurosis here described for the female was some kind of mental illness. Two-thirds (66.67 %) of the respondents saw this as a description of some kind of mental illness, though the symptoms described were no more severe than those of description C. On the contrary, one notices, that description C contains reference to violence, which is not indicated in description G. Of the respondents (43.14 %) saw this as a moderate disturbance.

Description H: Exhibitionism (male) - only just over half (52.94 %) of the respondents decided that this was not a description of some kind of mental illness. One-third thought of it as being a mental illness. There was thus an indication that some doubt and uncertainty with regard to this disturbance existed in the community.

Description I: Neurotic Depression (female) - no doubt, however, was expressed about this description. Almost three-quarter (74.51 %) of respondents agreed that this was indeed some kind of mental illness. Again, it can be noted that reference to violence (suicide) was prominent in this description. Furthermore, 60.78 per cent of the respondents saw this as a severe disturbance.

Description K: Drug Dependency (male) - this was not seen as a description of some kind of mental illness. However, it is surprising that only 50.98 per cent of the respondents answered in this direction. Seeing it as a mental illness were 37.25 per cent, while 11.76 per cent of the respondents had no answer to the question.

The community members were asked how they perceived the disturbance as it was described in the ten descriptions of the MOR questionnaire. They were asked for each description to indicate whether they saw the disturbance as being a mild, a moderate, or a severe disturbance. Table 8 lists the descriptions on a continuum from mild to severe disturbance as perceived by the community members.

(b) What does the community member see as mental illness, and which factors or variables as found in this study are grouped together with such a view?

As was indicated in the answer to the previous question, the community members see as mental illness such symptoms as described for simple and for paranoid schizophrenia, for anxiety neurosis in

Table 8

SEVERITY OF DISTURBANCE IN TEN DESCRIPTIONS AS PERCEIVED BY COMMUNITY MEMBERS

Severe	Severe	I. Neurotic Depression (female)	60.78 %
		A. Paranoid Schizophrenia (male)	43.14 %
	Moderate	D. Alcoholism (male)	37.25 %
		F. Juv. Character Disorder (male)	41.18 %
		G. Anxiety Neurosis (female)	43.14 %
	Mild	K. Drug Dependency (male)	37.25 %
		B. Simple Schizophrenia (female)	47.06 %
		H. Exhibitionism (male)	50.98 %
		E. Compulsive Phobic Neurosis (female)	60.78 %
Mild		C. Anxiety Neurosis (male)	64.71 %

the female, and reluctantly for anxiety neurosis in the male. Symptoms described from a female suffering a neurotic depression were overwhelmingly seen as being part of mental illness.

For the female anxiety neurosis, description G, a correlation significant at the one per cent level, was found with scores on the Maclean subscale: Social Distance (r = .4049). Community members who tended to score high on the social distance scale also tended not to see the female anxiety neurosis as a kind of mental illness. This suggests that some kind of denial exists in the community.

Again, a correlation, significant at the five per cent level, was found with scores on the Maclean subscale: Hospital committal and its consequences (r = -.3623). The lower scores on this subscale indicate a custodial viewpoint, while the higher scores indicate a more community-oriented outlook. Community members tending to score at the community-oriented end of the scale also tended to see the female anxiety neurosis as a kind of mental illness. Those scoring at the custodial end of the scale did not see this as a mental illness. This could indicate a lack of sensitivity to signs of mental illness, or the existence of some form of denial. Possibly both interpretations can be acceptable in this study.

It thus appears that the community member is most certain with regard to what is mental illness, when it is presented in a simplified format, with symptoms or behavior in 'black and white' appearance. It appears that anyone showing any of the behaviors mentioned in Table 9, singly, or especially in combination, runs the risk of being regarded as suffering from mental illness.

The symptoms recognized by the community members as indications

9

Table 9

ITEMS OF BEHAVIOR IDENTIFIED AS INDICATIONS OF MENTAL ILLNESS COMPARED TO FACTORS AS MENTIONED BY COSTELLO (1970)

Costello (1970)	Item of Behavior	Mentioned in:
Anxious intropunitiveness	Excessive worry and restlessness	10 studies
Hostile belligerence	Violence, threats of violence, loss of temper	9 studies
Perceptual distortion	Suspiciousness	6 studies
Paranoid projection	Ideas of reference	5 studies
Confused withdrawal	Withdrawal, daydreaming and lack of interest in surroundings	4 studies
Suicidal	Suicidal gestures	2 studies

of mental illness agree well with factors arrived at from an analysis of eleven factoranalytic studies of the symptoms of psychosis. In table 9 the items of behavior seen by community members in this study as indications of mental illness are compared to factors mentioned by Costello (1970). For the community member, however, suicidal gestures and violence appear more important than could be concluded from the emphasis these received in the eleven studies.

There is thus indication that the community members have accepted the views of psychiatrists and other professionals adhering to the medical model of mental illness. Further, it appears that less obvious cues for mental illness or rather mental disturbance, for emotional and behavior disorders, are not recognized by the majority of community members. It must, therefore, be assumed that much distress exists unknown in the community.

(c) Who in the opinion of members of the community are in need of treatment?

Community members were in agreement that all persons in the ten descriptions of the MOR questionnaire were in need of some kind of treatment. Only for description E, Compulsive Phobic Neurosis in a female, was there some indication of uncertainty. Thus 50.98 per cent of respondents thought she was in need of some kind of treatment, and 39.22 per cent did not think so. Unable or unwilling to answer were 9.8 per cent of respondents. Again, 39.22 per cent were unable to decide on where to refer this person. Nevertheless, almost half of respondents would prefer to direct this person to either a private psychiatrist or to the family doctor. Most agreement was achieved with reference to the male paranoid schizophrenic in description A. Only on respondent did not consider that person in need of treatment.

(d) Which type of treatment approach is perceived as being most effective?

According to the responses to the MOR questionnaire, preferred treatment approach can be indirectly assumed from preferences of referral indicated. Thus it must be assumed that the private psychiatrist, and treatment aa prescribed by him is seen as the most effective treatment approach. Table 10 lists referral sources from most preferred to least preferred as indicated by community members for the ten descriptions.

Similarly, some answers can be found from an analysis of responses to the Maclean scale, statements 2,7, 16, 25, and 30. The findings are set out in table 11 with comparison to findings from other studies where available.

Table 10

UTILIZATION OF REFERRAL SOURCES

Referral Source	Frequency of community members indicating preference	Percentages
Private Psychiatrist	126	24.71
Family Doctor	100	19.61
Child Guidance Center	56	10.98
Provincial Mental Hosp.	43	8.43
Social Service Agency	43	8.43
Parents	25	4.90
Local Health Department	24	4.71
Other	19	3.73
Clergy	11	2.16
General Hospital	2	.39
Police Agency	2	.39
Friends	2	.39
Employer	1	.20
Undecided	62	12.16

Table 11

ANALYSIS OF SELECTED ITEMS FROM THE MACLEAN SCALE

Statement	Study	Agree	Disagree	No opinion
The mentally ill should be put away in institutions (2)	Cumming & Cumming (1957)	49 %	9 %	-
	Maclean (1969)	43 %	44 %	13 %
	This study (1977)	41.18 %	58.82 %	-
As soon as someone begins to show signs of mental disturbance he should receive hospital treatment (7)	Maclean	94 %	3 %	3 %
	This study	47.06 %	52.94 %	-
Rest won't prevent mental disorder (16)	Maclean	no figures available		
	This study	60.78 %	39.22 %	-
Mental illness can be avoided by avoiding gloomy thoughts (25)	Maclean	39 %	no figures available	
	This study	19.61 %	80.39 %	-
Mental illness can often be helped by a holiday or change of scene (30)	Maclean	no figures available		
	This study	56.86 %	43.14 %	-

Though the contrast between agreement to statement 2, and 7, are not as pronounced as in the Maclean (1969) study, the suggestion that "custodialism is possibly masquerading in the guise of care" may still apply. The majority disagrees however with hospitalization and institutionalization. There is also no doubt that the community does not think treatment can be effective through a rest, or simply by avoiding gloomy thoughts. Nevertheless, community members do tend to believe that a holiday or change of scene may at least be helpful.

Causation of mental illness

(a) If the real problem is in the definition of mental illness, how does the community member see or define this ?

In addition to the suggested definition of mental illness seen in findings for question (b) in the previous section, it may be of value to examine the responses to a few of the statements of the Maclean scale. Thus the statements 8, 10, 35, 36, 38, and 39, all refer to personal characteristics of the mentally ill, and add to the statement of how the community member sees mental illness, and the mentally ill.

More than half (68.63 %) agreed that the mentally ill "seem to live in a different world", and 58.82 per cent agreed that they

Table 12

PERSONAL CHARACTERISTICS OF THE MENTALLY ILL

	Statement	Agree	Disagree
8.	Lives in a different world	68.63 %	29.41 %
10.	They are scarcely human	45.10 %	52.94 %
35.	Their eyes are glassy	11.76 %	84.31 %
36.	Strangeness (losing them altogether)	31.37 %	68.63 %
38.	Liable to commit suicide	74.50 %	23.53 %
39.	Have an untidy appearance	58.82 %	39.22 %

present with an untidy appearance, but there was some hesitation to suggest that the mentally ill were scarcely human (45.10 % agree; 52.94 % disagree).

As far as statements regarding the patients' supposed strangeness were concerned, the majority of respondents disagreed;

Statement 36: When a person becomes mentally ill, it is just like losing them altogether.
(Agree: 31.37 %; Disagree: 68.63 %)

Statement 35: Their eyes are glassy.
(Agree: 11.76 %; Disagree: 84.31 %)

The belief that mentally ill people are especially likely to commit suicide was held by 74.5 per cent of respondents (disagree: 23.53 %), and can be seen as further evidence for the continuing tendency to connect mental illness and violent behavior.

Thus the community member, in addition to regard the previously mentioned symptoms as indications of mental illness, also expects the mentally ill person to have an untidy appearance, to withdraw or live in their own, different world, and to be especially liable to commit suicide.

Further to the discussion of this question, it may be of interest to analyze responses to a few individual statements from the CMHI scale. Thus for example:

Statement 2 - More than half (60.78 %) of the respondents agreed with this statement; nearly one-quarter (22.58 %) of those did so strongly. The community member in this way indicated an acceptance of traditional diagnosing and treating the individual patients as being the optimal way for the professional to function.

Statement 11 - The belief in the traditional role of the mental health professional, and not seeing him as responsible for any innovative intervention role, was supported by the response to this statement. Thus 70.59 per cent of the respondents agreed, and of those a full 38.89 per cent did so strongly.

Statement 19 - There was, however, a change from the traditional view of the locus of mental illness as being within the individual. As a large group, 90.2 per cent of the community members agreed that the locus of mental illness must now be seen as extended into the family, the community, and the society. Of the ninety per cent, 58.7 per cent agreed strongly.

Statement 27 - Even more strongly was it held that a need exists for helping people not yet sick to develop ways for coping with expected life difficulties. Of those who agreed (90.2 %), 63.04 per cent did so strongly.

Statement 28 - In line with this, there is a belief that the focus should still be on the individual, more so than on an attempt at changing environmental factors. The majority, (64.71 %) agreed with this, and approximately a quarter of those (24.24 %) agreed strongly.

Statement 29 - The strong agreement (72.55 % agreeing ; and 45.95 % of those strongly agreeing) with this statement indicates the community member's strong adherence to the traditional, and his too willing surrender of power and involvement opportunities to the psychiatrist (the traditional professional).

Statement 35 - Nevertheless, three-quarters (76.47 %) of the respondents felt that the mental health professional should become an agent for social change.

(b) Does the community member see emotional/behavioral disorder (mental illness) as a result of intrapsychic processes or of external, environmental situations?

The majority of respondents (86 %) indicated that they would assume mental illness to be caused by environmental situations external to the person.

Interestingly, a correlation between this view and years of schooling received was found. The correlation, significant at the five per cent level, indicates that the more schooling a community member has received, the more likely is he to view mental illness as a result of intrapsychic processes.

As the previously indicated response to statement 19 of the CMHI scale suggests, there is strong agreement by community members that the cause of mental illness largely must be sought in the family, community, and the society. Similarly, responses to statement 27 support this. The community member, nevertheless, is still inclined to treat the individual in preference to modifying his environment (statement 28).

Ideology

(a) Which mental health ideology is accepted by the majority of community members?

Forty-two respondents (82.35 %) obtained CMHI scale scores in the upper two quartiles; 56.86 per cent scored higher than the mean score (184.90). From the CMHI scale scores, it must be concluded that there is a majority acceptance in the community of the community mental health ideology. On the other hand, it must be realized that the acceptance cannot be said to be overwhelmingly strong. Only 25.53 per cent of respondents scored in the upper quartile (210 - 266), and only 15.69 per cent of the respondents scored 222 or more - 222 being the lowest mean criterion score according to Block (1974).

From an analysis of responses to the thirtyeight statements of the CMHI scale, it was found that only to statements 2, 11, 18, 23, 28, and 29, did between fifty and seventyfive per cent of the subjects respond contrary to a CMHI oriented mode.

Responses to statements 2, 11, 23, and 29, indicate a too strong adherence to the traditional views and approaches of mental health professionals. Too easily does the community member accept the traditional.

Responses to statements 18, and 28, indicate that the community members are unaware of non-professional involvement opportunities, and does not fully appreciate the possibilities inherent in modification of the person's environment.

None of these responses indicate an inherent aversion to a community mental health approach. Results of a complete content analysis of the CMHI scale responses can be seen in the Appendix.

The scores supporting a community mental health view, obtained by community members of the two cities on three subscales of the Maclean scale further indicate the inclination of the community members toward a community care view:

(a)	Views of hospital committal and its consequences	(58.82 %)
(b)	Perceived public tolerance of the mentally ill	(64.71 %)
(c)	Social acceptability of the ex-mental patient	(66.67 %)

(b) What is the likelihood of consensus in the community with regard to mental health issues? Could the community members' ideological stand become activated to the point where pressure groups could be established in favor of a community care ideology?

Answers to these questions were sought in a contemplation of the return rate of the mailed questionnaires, as well as from comments and suggestions on the returned questionnaires.

A total of four hundred questionnaires were mailed out to the two urban centers, Edmonton and Wetaskiwin, in the province of Alberta:

		Mailed	Returned
Edmonton	(approximate population: 500.000)	300	33 = 11 %
Wetaskiwin	(approximate population: 10.000)	100	18 = 18 %
	Total	400	51 = 12.75 %

It was thought that a significant difference in response could exist between a large metropolis and a smaller urban center. A chi-square test (chi-square = 3.31) performed on the data, indicated that there was no significant difference between the return rates from the two cities. As the chi-square obtained was close to the chi-square value (3.48) which would have been significant at the five per cent level, it could be suggested that had the sample been larger, such a level could have been reached. A greater anonymity and beginning depersonalization and dehumanization of community members of a large metropolis might have been contrasted with that of a smaller, possibly more closely integrated center.

Return rate was rather small (12,75 %). Even if adjusted by taking into account undelivered mail (Babbie, 1973), it did not increase to more than 13.42 per cent. The low response rate was not entirely unexpected (evidence: Raj, 1972; Babbie, 1973; Kerlinger, 1973; Warwick and Lininger, 1975), though it did fall far below an expected forty per cent rate. Lowest rates usually encountered were mentioned by Miller (1970) as being about ten to twentyfive per cent, and by Selltiz et al. (1959) as about ten to fifty per cent.

On the basis of this it must be concluded that a certain apathy and lack of interest in mental health issues exists among community members of this study. Possibly this is in part a reflection of a severe lack of information concerning mental illness, and in part resulting from a process of denial utilized by community members facing a potentially threatening issue.

Consensus is unlikely at present, considering the apparent apathy and lack of information concerning mental health issues among the community members. This is supported also by the relatively wide range of scores on the CMHI scale (i.e. 100 - 257), and the fairly large standard deveiation (32.37). Various comments similarly indicate a lack of information about mental health issues. Informed knowledge must be seen as a prerequisite for establishing consensus. Several respondents made comments such as:

"General public not well enough informed on mental illness",

"Average citizen should be taught more about mental illness",

"Educate laymen in reality of mental illness, and mentally ill",

"Education to change public's attitudes",

"Community members should be trained towards developing greater understanding of the problems".

It may be possible after better information has been provided to encourage sufficient interest to form pressure groups in favor of a community care ideology. This, however, must be seen as a long-range projection.

Mode of Referral

(a) What is presently the preferred mode of referral?

The utilization of the various mental health resources listed in the MOR questionnaire for referral was previously indicated in table 10, page 221.

For all ten descriptions of the MOR questionnaire, the private psychiatrist, and the family doctor appear as one of the first three choices with the exception of descriptions H, and I. For the male exhibitionist (description H), the private psychiatrist was the third choice and the family doctor the fourth. First and second choice was, as could be expected, the Child Guidance Center, and parents. For the female suffering from neurotic depression (description I), the private psychiatrist was the first choice, the family doctor the fourth. Some community members (21.57 %) did recognize the social aspects of this description, and chose to refer to a social service agency (second choice), while 19.60 per cent would refer the person to a provincial mental hospital (third choice). The remaining distribution can be seen from table II in the appendix.

For six of the descriptions the number of respondents who did not indicate a preferred mode of referral was very low. For the remaining four descriptions, the number of respondents who did not indicate a preferred referral, were as follows:

Description E, Compulsive Phobic Neurosis (female)	- 39.22 per cent of respondents
Description C, Anxiety Neurosis (male)	- 19.61 per cent
Description K, Drug Dependency (male)	- 17.65 per cent
Description H, Exhibitionism (male)	- 15.69 per cent

Apart from description C, these were also not seen as suffering from mental illness, and perhaps the respondents either did not think any referral necessary, or were unable to see these as suffering in any sense from emotional or behavior disturbance, though in all cases the majority answered yes to the question whether they thought there was anything wrong with the person in the description. All descriptions (E, C, K, and H) were seen as mild disturbances.

Of those who did indicate a preferred referral for these persons:

51.22 per cent referred C to the family doctor,
41.94 per cent referred E to the private psychiatrist
27.45 per cent referred H to the child guidance center, and
25.49 per cent to the parents,
23.53 per cent referred K to the child guidance center.

(b) Does the community member react significantly different to the male and to the female disturbed person?

A comparison between the described anxiety neurosis in the female, and the similarly described anxiety neurosis in the male, suggests a discrimination in favor of the male and against the female. This was verified by a comparison between answers to the MOR questionnaire for description C, and description G.

Chi-square test for each question produced measures as follow:

"Would you say there is anything wrong with this person?"

Chi-square = 5.72; significant at the five per cent level

"Would you say this person has some kind of mental illness?"

Chi-square = 5.17; significant at the five per cent level

"Do you think this is a mild, moderate, or severe disturbance?"

Chi-square = 12.48; significant at the one per cent level

"Do you think this person is in need of some kind of 'treatment'?"

Chi-square = 9.65; significant at the one per cent level

It was, therefore, clearly indicated that discrimination against the female anxiety neurotic as compared to the male anxiety neurotic does exist in the community. Some prejudice against the female seems to be present also in a comparison of the two descriptions thought to be of severe disturbances: the paranoid male schizophrenic, and the female suffering from neurotic depression. Both descriptions indicated violence of behavior - in the male directed towards others, in the female directed towards the person herself. The disturbance in the male was seen as severe by 43.14 per cent of the respondents, whereas the disturbance in the female was seen as severe by 60.78 per cent of the respondents.

Community responsibility

(a) What today is the attitude toward mental illness, and the mentally ill, and what is the level of interest in mental health issues in the community?

Though the trend obviously is toward a more community care oriented view (82.35 % scoring on the CMHI scale in the upper two quartiles), only 15.69 per cent of the respondents scored 222 or more. Block (1974) indicated this score as being the lowest mean criterion score for the CMHI scale. The new attitude, therefore, cannot be said to be held strongly as yet. Much adherence to traditional views remain to be overcome.

However, when asked to agree or disagree with the statement: "Mental illness is something it is best not to talk about" (Maclean statement 5), 90.2 per cent of respondents disagreed. Of those, 82.61 per cent disagreed strongly. Thus the community members are favorably disposed towards the topic of mental illness. At the same time, the response may be seen as an indication of a need for more and better information.

The acceptability of the mentally ill was indicated by the fact that two-thirds (66.67 %) of respondents scored low on the Maclean subscale: Social Distance. To the statement: "People who are mentally ill ought not to be allowed to mix with ordinary people" (Maclean statement 13), the response was a strong disagreement. 90.2 per cent of respondents disagreed. More than half of those (54.32 %) did so strongly. This well supports scores obtained on the social distance scale indicating a willingness to absorb the mentally ill into the community.

Further, approximately two-thirds (64.71 %) of respondents in this study did not think that people nowadays are sufficiently tolerant toward the mentally ill.

At the same time it is of interest that only 24.51 per cent agreed with the invitation to benevolence toward the mentally ill (Maclean subscale: Explicit sympathy for the mentally ill), and 73.53 per cent of respondents chose not to express sympathy for the mentally ill.

In spite of such indications, the level of interest in mental health issues must be judged to be low. The return rate for the mailing of the questionnaires was 12.75 per cent (adjusted to 13.42 %). Thus a lack of interest, and apathy toward questions of mental health appeared prominent. Possibly this was in part a result of a process of denial. Further research in this direction is seen as a useful probability.

(b) Is the community now more ready and willing to accept community care of the mentally ill as compared to results indicated in other, previous studies?

Responses to the MOR questionnaire were utilized in order to provide some answer to this question. Table 13 summarizes results from the present study, and compares these findings from several other studies, using the six descriptions originally from work done by Dr. S. A. Star at the National Opinion Research Center at the University of Chicago in 1950.

Neither from this comparison (Table 13), nor from comments made by community members on the returned questionnaires, is it possible strongly to conclude that the present community is any more ready or willing to accept the mentally ill, than any of the communities studied in previous studies. However, the implications of this comparison will be discussed in detail in chapter VIII.

Facilities and resources

(a) Are existing alternative options of mental health facilities (resources) sufficiently well known to members of the community?

The data suggest that members of the community are rather poorly informed about existing facilities. As can be seen from table 14, very few alternatives not already mentioned in the questions of the MOR questionnaire were mentioned by the respondents.

Table 13

COMPARISON OF RESPONSES TO CLASSICAL DESCRIPTIONS FROM SEVEN DIFFERENT STUDIES

Description		Place	Anything wrong?		Mental Illness?		Disturbance			
			Yes	No	Yes	No	Mild	Moderate	Severe	(Serious)
A	a.	Blackfoot	91 %	9 %	69 %	31 %	-	-	45 %	-
	b.	Baltimore	95 %	4 %	91 %	3 %	-	-	-	78 %
	c.	Manhattan	-	-	100 %	-	-	-	-	-
	d.	Easton	-	-	89 %	-	-	-	-	-
	e.	Manhattan	-	-	90 %	-	-	-	-	-
	f.	Saskatchew	-	-	95 %	-	-	-	-	-
	g.	Edmt./Wetas	98 %	-	96 %	2 %	10 %	35 %	43 %	-
B		Blackfoot	70 %	30 %	36 %	64 %	-	-	15 %	-
		Baltimore	90 %	8 %	78 %	22 %	-	-	-	45 %
		Manhattan	-	-	72 %	-	-	-	-	-
		Easton	-	-	77 %	-	-	-	-	-
		Manhattan	-	-	67 %	-	-	-	-	-
		Saskatchew	-	-	67 %	-	-	-	-	-
		Edmt./Wetas	90 %	10 %	78 %	20 %	47 %	29 %	20 %	-

- continued

Table 13 (continued):

Description	Place	Anything wrong? Yes	Anything wrong? No	Mental Illness? Yes	Mental Illness? No	Mild	Disturbance Moderate	Severe	(Serious)
C	Blackfoot	55 %	39 %	20 %	74 %	-	-	-	-
	Baltimore	-	-	-	-	-	-	-	-
	Manhattan	-	-	50 %	-	-	-	-	-
	Easton	-	-	-	-	-	-	-	-
	Manhattan	-	-	31 %	-	-	-	-	-
	Saskatchew	-	-	-	-	-	-	-	-
	Edmt./Wetas	76 %	20 %	47 %	45 %	65 %	18 %	2 %	-
D	Blackfoot	60 %	32 %	25 %	75 %	-	-	90 %	-
	Baltimore	88 %	10 %	62 %	38 %	-	-	-	44 %
	Manhattan	-	-	63 %	-	-	-	-	-
	Easton	-	-	63 %	-	-	-	-	-
	Manhattan	-	-	41 %	-	-	-	-	-
	Saskatchew	-	-	71 %	-	-	-	-	-
	Edmt./Wetas	96 %	Nil	53 %	41 %	20 %	37 %	33 %	-

- continued

Table 13 (continued)

Description	Place	Anything wrong? Yes	Anything wrong? No	Mental Illness? Yes	Mental Illness? No	Disturbance Mild	Disturbance Moderate	Disturbance Severe	(Serious)
E	Blackfoot	-	72 %	4 %	-	-	-	-	-
	Baltimore	-	-	-	-	-	-	-	-
	Manhattan	-	-	40 %	-	-	-	-	-
	Easton	-	-	-	-	-	-	-	-
	Manhattan	-	-	24 %	-	-	-	-	-
	Saskatchew	-	-	-	-	-	-	-	-
	Edmt./Wetas	55 %	41 %	27 %	63 %	61 %	6 %	Nil	-
F	Blackfoot	83 %	-	4 %	-	-	-	-	-
	Baltimore	-	-	-	-	-	-	-	-
	Manhattan	-	-	30 %	-	-	-	-	-
	Easton	-	-	-	-	-	-	-	-
	Manhattan	-	-	41 %	-	-	-	-	-
	Saskatchew	-	-	-	-	-	-	-	-
	Edmt./Wetas	88 %	10 %	45 %	49 %	26 %	41 %	12 %	-

- continued

Table 13 (continued)

---

a. Cumming and Cumming (1957)

b. Crocetti and Lemkau (1963)

c. Dohrenwend, Bernard, and Kolb (1962)
   - sample of community leaders only

d. Meyer (1964)

e. Dohrenwend (1966); and Dohrenwend and Chin-Shong (1967)

f. Rootman and Lafare (1965)

g. this present study (1977)

Of the fifty-one respondents, 64.71 per cent answered, if mostly in a somewhat scanty manner to the question: "Please list facilities that are presently available in your community where individuals with problems similar to those described above could be sent for help".

(b) Do the community members have a clear idea of which mental health facilities and resources may be needed? Is there from the community a clearly expressed "felt need"?

Here again respondents did not seem to be particularly interested or aware of possibilities as only eighteen (35.29 %) answered this question. Two respondents felt that: "None" were needed, whilst another respondent simply desired: "More of

Table 14

AWARENESS/KNOWLEDGE OF FACILITIES NOW AVAILABLE IN THE COMMUNITY

Facility	No. of respondents mentioning facility
Social Services (i.e. AA, AADAC, Home Care Programs, PSS, Salvation Army, Social Workers, Sociologists, and Welfare Department)	33
School and Guidance Clinics	12
General Hospitals	12
Family Doctor	11
Provincial Mental Hospital	10
Clergy	9
Private Psychiatrist	9
Local Health Unit	9
Police and Probation Officers	7
Community Mental Health Service	3
Family Services (Catholic, Jewish, etc.)	3
Crisis Center	2
Mentally Handicapped (retarded) Institution	2
Community Psychiatric Nurse	1

That only one respondent mentioned the community psychiatric nurse, suggests that the visibility of this resource, which can be considered highly important, must be increased.

existing facilities". Table 15 indicates expressed "felt need".

Compared to listing of already existing facilities in the community, such as can be found in publications as for example: AID, a community services directory for Edmonton and district, the suggestions offered by community members, appeared to indicate a lack of knowledge, and a certain amount of apathy. A similar directory is available for Calgary and district.

Comments from the respondents did, on the other hand, often indicate a need for and a desire for better and more easily available information in the community.

Very few respondents utilized space provided for comments and suggestions, again possibly indicating an existing apathy and lack of interest within the community for mental health issues. Comments offered are here presented grouped together, as far as possible, with reference to topic of which they speak:

Information and Education

Already available resources need to be better known: and must cooperate.

General public not well enough informed on mental illness.

Community members should be trained towards developing greater understanding of the problems (this would facilitate rehabilitation).

Table 15

EXPRESSED FELT NEED FOR MENTAL HEALTH FACILITIES

Facility	Frequency facility mentioned
Guidance Center	21
Some agency with authority to intervene (Counselling of families) against the client's desire (esp. where children are concerned)	
Counselling Center sponsored 24 hrs. by government (no cost to clients)	
Counsellors, social services, etc., to intervene before anything has happened	
Places where you can go for talking over problems	
More consultation services (professional staff and trained volunteers)	
Mental health clinics for adults and children	
Centers dealing with socialization skills	
Facilities for teaching preventive measures as such facilities now are non-existent	
Mental health league to advise on local needs and prevention	
A crisis telephone (for referrals and information)	
A Depression center	
More private psychiatrists	2
Drug addict center	2
More provincial hospitals	1
Social Services Agency	1
Half-way houses, and total health care center	1
Social and mental hospital for mild "cases"	1
Out-patients at General hospital, but need improvement to be really available	1

Average citizen should be taught more about mental illness

Start education in schools and family (parents)

Make the use of existing facilities acceptable (just like going to the dentist)

Education for this to start pre-school at home, and followed in school

Also increase budget 200 per cent

Educate laymen in the reality of mental illness and mentally ill

Education to change public's attitudes

Criticism of resources

Workers (volunteers) at PSS have too many troubles of their own and have no ability to counsel others

Family Doctor does not know enough about mental illness, and the psychiatrist is too busy

Nobody seems to care what happens to anyone else

Evaluation

Evaluation of for example child care facilities; do they achieve any significant change in behavior of their clients?, or are they just warehouses?

Reassessment of welfare money recipients - do not give to those who can work

Evaluate mentally ill so that they are not released so early that they will harm others

Need of resources

Mental health workers to work more with employers, workers, organizations and the elderly

Lots of people need help before they actually obtain it

Problem today: People do not have anyone to turn to

Family services available before breakdown has happened

Manpower and administration

Use more volunteers and ex-patients

Authority to be given to someone to intervene with those at risk before incidence

More qualified people are needed, not just unemployed drifting from job to job

More trained mental health field personnel: Educate public, and volunteer helpers, and treat society as a whole

Services should be provincially, not locally administered, and only professionals should be responsible for policy decisions

Prevention

More preference should be given to projects concerning "the elements of the causes of mental health instability"

Concerning the questionnaires

Questionnaire difficult: many types and degrees of mental illness. Answers would differ for someone harming others, and someone harming themselves

Too many questions

Filling out questionnaire made me more aware of problems connected with mental health and mental illness issues.

CHAPTER VIII

DISCUSSION AND CONCLUSIONS

The present trend to move the mentally ill from traditional, institutionalized hospital care to a more liberal community care was seen as a situation in which the community development agent could apply his special skills to assist the community in facilitating such a transition. At the same time this was seen as an opportunity and a challenge for the community development agent that he could utilize to encourage and strengthen a psychological sense of community.

Initially the concern would be with the transition of the mentally ill from a hospital setting to full acceptance as members of the community. This would call for attention to questions concerning consequent need for aftercare modalities and resources. The primary objective of the study, however, was to assess community members' views on mental health issues. This was done in an attempt at gaining an understanding of the readiness of the community members to receive the mentally ill back into the community, and to retain within the community, persons found suffering from emotional or behavior disorders. On the basis of findings from the study, the feasibility of utilizing the community development strategy of primary preventive intervention as a community approach to the problem of mental illness, was discussed.

Any primary preventive intervention undertaken by the community development agent must be introduced into the community. It must be part of a process seen to strengthen horizontal linkages within the community, to counter alienation, segregation, and estrangement of members of the community. Furthermore, it must be an effort to give expression to the community development values of fraternity, participation, responsibility; a commitment to develop and strengthen relatedness, rootedness, and a sense of identity. As the change agent will be directly concerned in this way within the community, the study sought to discuss and analyse what can be accepted as a community. It was suggested that a psychological sense of community is needed. Community must again become communitas (fellowship). It must become a functional unit defined by the mutual sharing of experiences and communication between members. It must be based on a perception of similarity to others, an acknowledged interdependence with others, and a willingness to maintain such interdependence through a feeling of being part of a larger, dependable and stable structure. Within such a functional network of interacting relationships the so-called mentally ill can become integrated again as full and useful members of the community.

If the community development agent is to be successful in utilizing the present opportunity and challenge to develop and strengthen a psychological sense of community; if he is to aid the community to reintegrate its "mentally ill" as part of a move towards a future more healthy community, some clarification of the concept of mental illness, must be considered essential. The study, therefore, presented a theoretical discussion of how man through time has perceived mental illness and its causes.

Treatment approaches and concerns about mental health issues are largely determined by the ideology subscribed to by the community members. Thus the kind of intervention thought suitable and effective will depend on the kind of assumptions the community members make about mental illness.

In order to find out the way in which mental illness is perceived by the members of the community, the study made use of three research instruments; i.e. the Baker-Schulberg community mental health ideology scale, the Maclean opinion and attitude statements scale, and the Mode of referral questionnaire.

A full discussion of these three instruments is given in this study, in chapter VI, pp. 181 - 190.

A package containing the three instruments was mailed to a sample of 300 and 100 individuals from Edmonton and Wetaskiwin respectively, selected by systematic random sampling from the relevant telephone directories.

The mailing of questionnaires was chosen for this research as mailing to a large number of individuals could be done simultaneously, and at reasonably low monetary expense. It was realized that many of the respondents might not care to complete and return the questionnaires. It was, however, hoped that the mental health issues would be of sufficient and urgent importance to a large number of community members, to overcome such reluctance.

Nevertheless, the problem of returns became a major issue. Thus, though 400 questionnaires were mailed out, and it was expected that approximately 40 per cent of these would be returned, the actual return was only 12.75 per cent.

Selltiz et al. (1959) mention a return rate from about ten to fifty per cent for mailed questionnaires. Further the literature suggests that ten per cent may be acceptable for analysis of data, as it is extremely difficult to obtain higher return rates by the method of mailed questionnaires. It was decided to use the results for analysisin this study, if after two to three follow-up attempts ten per cent or more was returned. The return rate was found to reach 13.42 per cent, when adjusted for undelivered mail (Babbie, 1973).

Because the sampling utilised in this study was somewhat unbiased, it was thought that 13 per cent return would provide relevant information about peoples' attitudes, ideology, preferred mode of referral, etc. It was, therefore, decided to utilize the actual return for this study.

Possibly an interview method would have been more informative. More people might have been willing to cooperate had they been approached by an interviewer. Not only could this have yielded a higher response rate, but it would have allowed a fuller understanding of the subject's responses.

With the low return rate obtained in this study, it was thought justified to conclude that a certain apathy and lack of interest in mental health problems exists among community members. Possibly this is in part a reflection of a severe lack of information concerning mental illness, and in part an indication of a process of denial utilized by community members facing a potentially threatening issue.

Hypothesis 1

It was hypothesized that a significant relationship exists between the ideology of mental illness preferred by the community member and his preferred mode of referral. The results indicated that this hypothesis could not be definitely supported from this study. A positive significant (p .05) correlation was found only with preferred mode of referral for description E, that of a young woman suffering from a compulsive phobic neurosis. This suggested that the lower the community member's adherence to a community mental health ideology was, the more likely he was to suggest referral to a custodial-oriented facility for this young lady. Her disturbance was seen as being mild and not a mental illness. Nevertheless, 18 per cent would refer this person to a provincial mental hospital, and another 25 per cent would refer to a private psychiatrist.

Though not reaching levels of significance, there was some indication of support for the hypothesis in the correlations for the remaining descriptions. As can be seen from table 2, and figure 1, the general trend is in the direction suggested by the hypothesis. The only negative correlation approaching the five per cent level of significance in any noticeable way is for description G, that of a woman suffering from an anxiety neurosis. This was thought to be an indication of a discriminatory attitude toward women as will be discussed later.

Had the sample and the response rate been larger, it is likely that support for the hypothesis would have been more pronounced. Again, had the referral options been more clearly separated into a custodial-oriented group, and a community care-oriented group, the hypothesis might have been more obviously supported.

Assuming then that it is correct to say that the hypothesis is partly supported, and would have been so more explicitly had some of the factors involved been slightly different, the implication of this for the community development agent is that ideology is very much important in the question of mental health issues. The ideology preferred by the community member does determine the way in which he will approach the problem of mental illness in actual referral situations. As an acceptance of a community mental health ideology inclines the community member to refer persons suffering from emotional and behavior disorders to community care oriented facilities, the community development agent will seek to inform and educate the general public in the principles and assumptions of such an ideology. As a preparation for acceptance of community care, such information and education should be widely and frequently attempted throughout the media. Provision of education and information can be seen to be an important aspect of the community development agent's intervention. His involvement with mental health issues, therefore, is a community development process of major importance for the community and its members.

Hypothesis 2

To the suggestion to list facilities presently available in the community to which persons with emotional or behavior disorder could be referred for help, 65 per cent of the respondents reacted. The answers were for the most part scanty, listing no more than one or two facilities. Only a very few respondents listed more than three facilities. Table 3 indicates the facilities mentioned as well as the number of respondents mentioning each. Notably, social service of one kind or another was mentioned by all respondents. Thus the community members mentioned the AA, AADAC, PSS, Home Care Programs, the Salvation Army, Social Workers, and the Welfare Department. Most of these services are well publicised via the media, and some, such as the Salvation Army, are highly visible in the community. Next in frequency of being mentioned were General hospitals, and School- and Guidance clinics. Again, these are very much visible, and most, if not all community members have had some direct contact with at least one of these. Both were mentioned by 36 per cent (12) of the respondents answering, though not the same twelve community members. Only 39 per cent (11) of those answering the question mentioned family doctors. In view of the frequency with which the family doctor was chosen as a referral factor, this was an unexpected low number.

Only 30 per cent (10) mentioned the Provincial Mental Hospital, though its visibility and publicity is high. Possibly the stigma still attached to a provincial mental hospital inhibits even acknowledging its presence; possibly this low response was part of a process of denial. Remaining facilities mentioned were so by less than 27 per cent (9) for each. Community mental health services were mentioned by less than 9 percent (3) of respondents answering this open-ended question; the community psychiatric nurse by only one respondent.

Comparing the subjects' responses to facilities and resources listed in a publication such as AID, a directory of community services for Edmonton and district, it becomes obvious that the public is rather poorly informed concerning available facilities and resources. This is realized by the public itself as evidenced from comments and suggestions offered (v. table 15). Again, the implication is that there is a need in the community for a better and more easily available information and education service.

Though the social services as mentioned by the community members have been providing valuable and laudable service, they are in their present form totally inadequate to meet requirements as arising from a move of the mentally ill back into the community. This is partly due to a shortage of manpower (Reiff, 1967). As pointed out by Albee (1965), there are twenty jobs for each MSW graduate, and:

> The manpower demands projected over the next twenty years in the fields concerned with professional care for people with emotional disorder are so far beyond the probable supply of people available as to constitute a major national crisis.
>
> (p. 63)

The resources of existing facilities are spread out too thinly in an attempt at covering many aspects of social service by a single agency, with unavoidable overlapping. Further, they are aimed at rehabilitation, whereas what is required is an emphasis on prevention. As a first step in this direction some eight categories of service were discussed on pages 127 - 141. In addition to those must be strongly suggested an extension of the use of non-professional personnel.

A change from a medical model of mental illness to a socio-psychological, a community mental health oriented model of emotional and behavior disorder, will make possible the utilization of non-professional caregivers and urban agents. These persons will assume new preventive roles, seeing persons suffering from such disorders as people, human beings, rather than as more or less incurable objects. Again, the non-professional will be more free to engage in trial-and-error behavior, which on a human basis will be more likely to succeed than the rather rigid professional approach to problems. For some disturbed persons a less pronounced social distance for the helper is likely to be a potent factor in a successful outcome of social interaction.

The community development agent here has an opportunity to utilize his special skills to encourage in the community members a sense of involvement, enthusiasm, and dedication to the solving locally and preventively of mental health issues. This will enable the community to utilize the resources of indigenous neighborhood workers, who may be extremely valuable in their efforts to prevent "mental disorder" by capitalizing on shared experience, which generally would not be possible for the professional mental health worker. Physical facilities may be less important than the involvement of parents, teachers, retired persons, housewives, and both college and high-school students in an effort to make the process of the community a more healthy one mentally.

The community development agent stimulating community action by indigenous persons in the community is assisting the members to deal with the problems where they are likely to occur. The emphasis being on expected normal behavior rather than sick behavior will encourage such behavior in the community members. In strengthening a psychological sense of community, the agent may encourage the use of community members with emotional problems themselves to help and deal with others with similar problems. Thus for example, the retired person, becoming increasingly isolated and lonely, may be encourged to assist other retired persons, thus avoiding the sense of being a burden to society; the housebound housewife may establish meaningful social interaction with other housebound women, thus becoming an important local agent in the effort to strengthen a psychological sense of community, and an invaluable part of the preventive community development intervention.

A wider and more fully utilization of existing community resources with less emphasis on the organizing of these into rigid physical facilities may be an extremely important step toward changing social systems of the community for the benefit of the total community. Rather than the extension of and creation of new facilities, an emphasis on the learning by the community members of techniques of social interaction and social conditioning is needed. The community development agent can here well apply his skill to training non-professionals in making early assessments of potentially harmful situations within the community, and in making referrals to the appropriate modalities of community members at risk, or showing an indication of emotional and behavior disorder.

Hypothesis 3

The hypothesis that the community members are largely accepting of an community mental health approach, and to a significant extent dissatisfied with the present attitude to the mentally ill was supported by the results. The distribution of scores obtained on the CMHI scale suggest that the sample is that of a fairly heterogeneous group. The scores were expectedly low, yet 82 per cent of the respondents were found to have obtained scores in the upper two quartiles. Thus it must be concluded that the community members as far as they in reality understand it, are supporting an acceptance of a community mental health ideology, an approach focusing on the total community population as opposed to an exclusive interest in the individual, a concern with preventing mental illness through environmental intervention, and an approach seeking the involvement of a variety of community resources in mental health issues.

Comparing the scores obtained in this study to scores in the literature, it was found that only county physicians of the Perkins and Thompson (1974) study had a mean score that was lower. Only the Society for Biological Psychiatry (SD = .87), and the American Psychiatric Association (SD = .97) presented with a larger standard deviation. As could be expected, out of the eleven groups mentioned in table 4, only these two groups, apart from the county physicians and community members of the present study, would be less inclined to accept a community mental health view. Both groups, more than other groups, could be expected to contain members with greatly varying opinions. The relatively large standard deviation in the county physicians' group may indicate a lack of interest in mental health issues among members of this group, and a lack of willingness to pay the same attention to psychological problems as to physical illness. According to Bandler (1968), Farnsworth (1968), and Williams and Ozarin (1968), there does not seem to be any serious inclination among physicians to consider the role of psychological factors in physical illness.

Therefore, referrals to these sources that appear especially obstructive to an acceptance of a community mental health view, may delay or entirely thwart efforts at inducing the community members to make full use of alternative community care resources as could successfully introduce a generalized preventive approach.

Thus it appears necessary to educate and inform the community members of possible alternative resources and of the entire philosophy underlying the concept of community care.

The Baker-Schulberg (1967) finding of a significant relationship between obtained scores on the CMHI scale and subject's age was only partly confirmed by this study. Five age groups were tested for significant differences between the mean scores obtained. The t-tests of all interpair differences can be seen from table 6. Only between group V, and groups I, II, and III were differences significant at the five per cent level found. It can be speculated that a larger sample might have supported the Baker-Schulberg findings more clearly. A more intense effort is required to educate the older person, and a need exists to provide more and clarifying information on the concept of community mental health to this group; information more directly relevant to the needs of this group.

A correlation significant at the five per cent level was found between years of schooling received and way of perceiving causation of mental illness. The more schooling received (thus also older), the more mental illness was seen to be caused by internal factors. This indicates a need to change concept education at an early age, as prolonged exposure to a medical model and pseudoscientific propaganda appears generally to increase resistance to the concept of community care.

The possibility that a difference might be found in male/female scoring on the CMHI scale was tested by chi-square, but no significant difference was found. Nevertheless the obtained chi-square (2.09) was approaching the five per cent level of significance (3.84). A larger sample might have shown a significance in difference in scoring. In the present sample, mean scores for males and females were respectively: 187.77, and 178.63.

The finding by Wagenfeld et al. (1974) that adherence to a community mental health ideology was stronger in centers serving all rural areas as opposed to inner city urban areas, could not be supported from this study. A chi-square test on the scores obtained in a center serving rural areas (Wetaskiwin), and one serving an inner city urban area (Edmonton) indicated no significant difference in this study. Should a more comprehensive study support the Wagenfeld et al. (1974) finding, it would indicate a need for a more intensive education and information campaign in urban areas. The community development agent may well act on the assumption that this will be found valid.

The hypothesis suggested that community members would be dissatisfied with the present attitude to the mentally ill. The results supported this part of the hypothesis. Indeed, 65 per cent of the community members responding found that people nowadays are not sufficiently tolerant towards the mentally ill. This is a good foundation for the community development agent to work on. Compared to the Maclean (1969) finding, where 60 per cent of the respondents were satisfied with the existing level of tolerance, this is a complete reversal of opinion. Maclean suggests that the apparent complacency in her sample could be a result of the subjects contrasting the then existing climate with that of earlier times. This suggestion does not seem at all applicable in the present study. The dissatisfaction expressed here, on the other hand, may be only partly due to a genuine concern about mental health issues. In part it may be an indication of the less stable period in time (1977), i.e. part of a generalized reaction to difficult and stressful times. The community development agent may utilize this both to generate a more explicit interest in preventive intervention, and also to develop and strengthen a psychological sense of community.

Hypothesis 4

The results support and suggest that the community members do tend to reject the mentally ill when the disorder is seen as an exaggerated deviation, but are accepting towards the mentally ill when the disorder is perceived as less exaggerated. Thus it was seen that the greater the social distance was expressed to be for the community member, the more he tended to see the paranoid schizophrenia, and the simple schizophrenia as being less severe disturbances. Similarly he tended to see nothing wrong with the persons suffering from simple schizophrenia, and neurotic depression. Furthermore, he tended to see the descriptions of simple schizophrenia, compulsive phobic neurosis, and anxiety neurosis in the female as being descriptions of situations which were not mental illness.

It, therefore, appears that rejection is greatest for disorders, which may present as exaggerated deviance. At the same time, the community member can be seen to utilize denial as his reaction to mental illness, and/or being relatively unable to recognize indications of mental disorder, even when pronounced. This is in agreement with the findings by Phillips (1964), that there is a stronger rejection of some exaggerated deviating behavior than of less exaggeratedly deviating behavior.

Crocetti, Spiro, and Siassi (1974) suggest that the fact that Baltimore respondents in the study by Lemkau and Crocetti (1963) could identify three Star vignettes as indications of mental illness is contrary to a support for the concept of denial. However, it must be pointed out that the subjects were not asked to identify persons at large in the community (i.e. diagnose), but to identify a given description. That they can identify various "cases" does not mean that they are not also using the process of denial. In support of this also was that the community members found the persons described in all ten descriptions to be in need of some kind of treatment and help. It thus appears that the community members tend to attempt to blot out portions of their world involving mental health issues, possibly seeking to avoid being overwhelmed with anxiety.

The relationship between denial and depersonalization as discussed by Weckowicz (1970) could in this context give rise to some important future research. For the community development agent depersonalization, deindividuation, and dehumanization are important concepts. These give rise to the social problem of situations which lead most people to treat others as if they were not human beings with a personal identity. To counter this trend existing in the community, as suggested by the results of this study, intervention in the form of socialization training and programs of reindividuation may be useful. At the same time that such intervention will counter a state of anonymity forced upon the individual, especially in urban centers, it must allow for an increased psychological sense of community. The community development agent can seek to achieve this through supporting the reestablishment of intimate contacts for community members, largely through a strengthening of the family, and of relationships with neighborhoods. Further, he will seek to induce environmental manipulation in order to arrange the physical environment of the community member in such a way that it provides optimum opportunity for intimate contacts, increased and intense involvement in the larger fabric of the community and of society.

Hypothesis 5

Finally it was hypothesized that in spite of attempted mental health education over a long period of time, members of the community still view the mentally ill as violent and dangerous. The results supported this hypothesis in that 55 per cent of the respondents indicated that they saw in the mentally ill a source of possible danger to the community. Comparing the results of this study with those of Belson (1957 a), and Maclean (1969), it appears that members of the communities studied in those studies were less inclined to see the mentally ill as dangerous than members of the Edmonton and Wetaskiwin communities now are. Viewed against the background of changes in the total world picture over the last twenty years, it may indicate an increase in anxiety level among members of the general public.

Indications are that past attempts at educating the public as to the non-dangerousness of the mentally ill have failed. Educational efforts have neither been sufficiently intensive, nor probably correctly aimed. Thus, rather than simply to suggest the non-dangerousness of the mentally ill, the emphasis should be on enlightening the community members to the factors responsible for aggressiveness whether encountered in the mentally ill, or in anybody else. The importance of social system change to control this human characteristic should be emphasized, and governmental action supporting demonstrator projects and research should be obtained and secured. The problem of aggression and violence must be seen as a general human problem shared by all, and not as especially an aspect of so-called mental illness. For the community development agent various possibilities suggest themselves. He may utilize the concept of empathy, arising from an emphasis on the similarity between people. Various modes of contingency management may be introduced, and in order to lower aggressive tendencies in the mentally ill, and not least in the community members in general, tolerance training, as suggested by Skinner (1962; pp. 87 - 90) could be found valuable. A continued research into the causation and control of aggression and violence must be supported. An attempt at inculcating humanistic values as opposed to materialistic ones, will do much to establish behavioral-, environmental-, and social control. Further, an increased utilization of social indicators to indicate situations that lend themselves to aggressive responding, would be part of an effective preventive intervention in the community.

Various issues

Community members saw six of the presented descriptions as being of persons suffering from mental illness. Only the persons described as suffering from compulsive phobic neurosis, from drug dependency, and a fourteen year old boy having exposed himself, were seen as not suffering from mental illness. Some doubt was evident with regard to a twelve year old boy with a juvenile character disorder. This was seen by 45 per cent as a mental illness, while 49 per cent did not agree with this. Thus it appears that the respondents feel most certain as to what is mental illness when symptoms are pronounced and in accord with symptoms traditionally stated by mental health professionals (v. table 9). The less obvious cues for emotional and behavior disorder were not recognized. This suggests that the public utilizes the medical model of mental illness as a reference model, likely because no other model has received as much exposure and publicity. Thus it must be anticipated that much unrecognized suffering and emotional agony exists in the community. Mental health education both with professionals and the general public is indicated.

All ten persons described were seen as being in need of some kind of treatment, and most frequent referrals were to the

private psychiatrist, closely followed by referral to the family doctor (v. table 10). Realizing that these are the two groups from whom support for a community mental health view is least likely to come, it is obvious that the referral pattern of the community members must be changed. The results indicate a need for education and provision of information regarding community care, again both for the professionals and for the general public.
As in the Maclean (1969) study, the suggestion that "custodialism is possibly masquerading in the guise of care" probably applies to the respondents of this study as well. The community development agent will need to familiarize the community member with alternative options of mental health resources, and encourage a sense of responsibility for their fellow human beings.

Though the respondents largely accepted traditional expressions concerning mental health issues, this appeared to be mainly due to a lack of knowledge of other, more recent trends. Nevertheless, ninety per cent felt that a need exists for helping people not yet sick to develop ways for coping with expected life difficulties. As large a group as ninety per cent of the respondents also agreed that the locus of mental illness must now be seen as extended into the family, the community, and the society. They do not yet, however, feel that the emphasis should be moved to attempts at changing the environmental factors in preference to treatment of the individual. Again, this may be due to lack of knowledge of new approaches, and the concept of primary prevention.

It was previously suggested that a process of denial exists in the community. The strong agreement with statement 29 of the CMHI scale (72.55 %) suggests the dominance of a passive-dependent mode of behavior among the community members. There is thus an indication for the community development agent to seek to overcome such passivity. Again, contingency management and reinforcement theory may be applicable.

Frequently in the study, indications of the need for the community members to become familiar with possibilities inherent in environmental manipulation, as well as with opportunities for non-professional involvement, became obvious. There was a clearly expressed need for further information and education in mental health issues in suggestions and comments from the respondents.

There was an indication of discrimination existing against the female finding herself in the throe of emotional and behavior disorder. Possibly the women's liberation movement, and consciousness-raising groups for women could be supported by the community development agent as one possible attack on this unfortunate tendency.

A comparison of responses to classical descriptions from seven different studies (v. table 13), did not make it possible to find the present community more ready or willing to accept the mentally ill, than any of the communities studied in the previous studies. Nor did it make it possible to support conclusions reached by Crocetti, Spiro, and Siassi (1974).

Crocetti, Spiro, and Siassi (1974) suggest that the increase in percentage able to recognize mental illness (as presented in the Star descriptions) contradicts previous explanations for underutilization of services. Further, they suggest that this also weakens attacks on the medical models of emotional disturbance, and in no way supports a "theory which equates psychological disturbance with social deviancy" (p. 53)

In the present study an increase in percentage recognising mental illness was seen for four of the descriptions. Percentage for one description remained the same as for the Baltimore study, and for one description there was a decrease compared to the Baltimore study. The decrease in percentage of subjects recognising, or seeing, the male alcoholic as suffering from mental illness, from the Baltimore study to the present study was from a 62 per cent to 53 per cent. If this cannot be accounted for by chance, it probably indicates not that less subjects are able to identify a mental illness, btu that the general public have become more tolerant and understanding of the alcoholic. The governments have, especially in the area of alcoholism, produced a wealth of easily available information. The question of alcoholism has been widely publicized in the media, and throughout all community services. Thus, this may be taken as an indication of the effect of well-directed information and propaganda, and that the public is beginning to learn that alcoholism indeed is not a mental illness, even measured by traditional medical model definitions (Finlay, 1974).

We are looking at intervals of six, fourteen, and twenty years between the studies. During this time, and especially throughout the sixties, much progress was made in public health education. This supported mainly a traditional presentation of mental illness. Further, indications from this study suggest a passive-dependent acceptance of authority and traditional approaches among the community members. This again, would tend to uphold definition according to medical models. In none of the studies has it been possible to ask the subjects to identify community members at large as suffering from mental illness. One must assume that there is a tendency for the subject to expect mental illness in the presented descriptions; it may, however, be rather more difficult to test the subject's capacity to even recognize in vivo, indications of emotional or behavior disturbance. Results from this study suggest that the community member does not easily recognize cues for mental illness, nor for minor emotional or behavior disturbances.

Thus it can be concluded that due to lack of publicity the non-medical models are rather unknown to the general public. It can, therefore, not come as a surprise to find that they will accept traditional descriptions as being of mental illness. At the same time results from this study indicate a desire in the community for the community members to become better informed as to the causation of mental illness, and a desire to accept a community mental health orientation to so-called mental illness. Indeed, throughout the results a certain amount of dissatisfaction with medical model approaches to the problem of mental illness is clearly evident.

CHAPTER IX

PREVENTION AND FUTURE TRENDS

Preventive Approaches

Statistics Canada reports that the number of patients on books as of December 31., 1976, receiving mental health care were:

Canada: 50,559 (approx. .23 per cent of Canada population)
Alberta: 4,489 (approx. .45 per cent of Alberta population)

For all of Canada the figure represents a decrease of five per cent from the previous year, and twentyfour per cent since 1969. For Alberta the corresponding figure represents a decrease of six per cent from the previous year, and twentytwo per cent since 1969.

That we are not dealing with an insignificant, small problem, however, can be seen from the fact that the number of admissions in 1976 for all of Canada show an increase of twentythree per cent since 1969. Correspondingly, the number of admissions in 1976 for Alberta show an increase of twentyfour per cent since 1969.

Thus obviously there is an increasing demand on treatment facilities and services for those suffering from emotional and behavior disorder. A continued increase is not desirable, and the focus on treatment of mental disorder must change to a focus on preventing the development of such disorder in the first place. This is not a new suggestion. In the early 1900's, one of the most influential psychiatrists of the 20th. century, Dr. Adolph Meyer, strongly supported the idea that the hospital should extend its activity into the community, and proposed that emphasis be placed on attempting to prevent development of mental illness. Nevertheless, his ideas and even the introduction of preventive approaches into general medicine, failed to stimulate efforts in the prevention of mental disorder.

It was not until 1944 with Lindeman's (1944) study of bereavement, previously mentioned (p. 134), that a renewed interest in prevention arose. The Wellesley community mental health program (Klein and Lindeman, 1961) became a laboratory for testing broad preventive technique, and a few years later, Caplan (1964) wrote his book suggesting ways to establish preventive programs. Much of the existing work in prevention is still based on the ideas and principles of Caplan, and is very much similar to the concept as found within the Public Health Medicine, which had its modern origin in the latter half of the 19th. century. This approach was a clear example of a total community mobilizing resources in the face of serious plagues and epidemics threatening to wipe out the community (Brown, 1969). As prevention does not seek to deal with the problems of the individual directly, but is aimed at intervention involving the total community, it can indeed be seen as a community development intervention. Not only in this way, but prevention of mental disorder is not only an activity for the experts, but in a sense is everybody's job. Prevention is rooted in the institutions of the community, in the capacity for social control, or societal guidance, present in the family, the school, in the church, in industry and business, etc., and thus lies at the very heart of the community development concept.

The mental health field has divided the broad concept of prevention into three components - primary, secondary, and tertiary prevention (Caplan, 1964; Sanford, 1965; Cowen and Zax, 1967). According to Caplan, primary prevention is concerned with reducing the incidence of mental disorder in the community; secondary prevention is efforts aimed at reducing the duration of mental disorders, which have already occurred in the community, and tertiary prevention is concerned with measures to reduce impairment having arisen from already present mental disorders. Traditional psychiatric practice has taken secondary and tertiary prevention as its area, but has left primary prevention untouched. Both secondary and tertiary prevention is well within the confines of the medical model, and especially so the latter. Secondary prevention does however occupy a somewhat ambiguous position. In one sense secondary prevention seeks to reduce the duration of mental disorders already present in the community by identifying and treating such disorders as promptly as possible. In this sense secondary prevention belongs within the medical model, but in another sense, longitudinally, secondary prevention is concerned with early identification and intervention with children as soon as a first indication of later serious disorder occurs. In this second sense, it may be said to fall outside of the medical model and can be seen as part of a community development approach. However, as we utilize terms such as treatment and rehabilitation as well to cover what has been defined here as secondary and tertiary prevention, the usage becomes confusing. Wagenfeld (1972) has suggested that only the term, primary prevention, be retained. This offers a contrast to the medical model, and enables primary prevention to be seen as the community development strategy par excellence.

The selection of a strategy of primary prevention is much influenced by the ideology accepted, by the model of mental illness acceptable to the community members. Accepting the medical model, one is forced to seek some pathogenic factor which must be reduced, or better eradicated. Symptoms of mental illness is here viewed as representations of intrapsychic events. This extraordinarily limits and narrows legitimate areas for intervention. Secondary, and especially tertiary, prevention must be the strategy of choice. Yet, even then some psychiatrists have attempted to see a causal relationship between social factors, labeled pathogenic and individual psychological functioning. They have sought to justify a medically based intervention in social change areas, and attempted to present it as being free of ideological influence. Thus e.g. Pinderhughes (1966):

> Much activism of doctors which is viewed as political or civil rights activity can be defined clearly as corrective or preventive medical activity also. By doing so, additional support may be gained in some instances and resistances to change weakened in others.
>
> (p. 424)

This view can but be considered naive, and has been attacked by several psychiatrists and social scientists (e.g. Szasz, 1961; Mechanic, 1966; and Leifer, 1969). There can be no doubt, that the ideology accepted by the community member and by the change agent, or professionals, attempting primary preventive interventions, to a large extent determine possible and acceptable approaches. It is interesting to note an observation by Marx (1969) that the less the problems of a field are understood, the more significant is the ideology subscribed to in determining the programs of action and the approaches selected for dealing with and successfully solving the problem. Community mental health and the concept of primary prevention with reference to so-called mental illness, are two such fields within which ideologies have great significance. Thus Baker and Schulberg (1967) have convincingly shown the existence of a distinct ideology among the adherents of the ideas and principles of community mental health. Similarly Peck, Kaplan, and Roman (1966) made a statement of a primary prevention-oriented community psychiatry:

> In all of our endeavours the basic assumption has been that there is an intimate relationship between the social organization of the community and the individual psychological organization of its residents.
>
> (p. 60)

It is this view that underlies a community development approach to the question of how to treat mental illness, and is one of the main reasons for the value of community development's strategy of primary preventive intervention. Though this view is basic, there is not with it the delusion that we shall find a one-to-one relationship between social organization of the community, and psychological organization of the individual community member. This has also preveiously been emphasized in the writings of Durkheim, and by Fried (1964), who pointed out that many of the more obvious factors involved, such as income and social stability, nutritional state and health, education, residential status, type of work performed, and psychological and emotional deprivation and adjustment, only bear "approximate correspondence with one another" (p. 411).

As just previously mentioned, the ideology acceptable to the community member, to a large extent determines the success or not of any intervention process. For community development to be successful in the field of mental illness, a move from the medical model toward a preventive model must be achieved. Through a very long time, and predominantly even today, it appears to be generally assumed that physical and psychological dysfunction have similar onset and developments. Nevertheless, at the same time it is widely accepted that psychological dysfunction more often develops slowly over a long time, and is more determined by experiences, by reinforcement behavior of significant people in the subject's circle, and by environmental settings.

Thus a move has taken place from viewing mental disorder as being primarily related to a person's internal make-up to seeing disorder more as reflecting particular social contexts. This question of underlying ideology and approach has great importance not only for choice of immediate techniques and approaches, but especially for long-range planning in mental health, as also suggested by Lennard and Bernstein (1969).

A successful community approach to "mental illness", therefore, will reflect important environmental stresses as well as intraindividual ones. In order to deal effectively with such, greater emphasis must be placed on environmental engineering and modification.

The community aided and supported by community development principles, will seek to use community settings and resources to cope with already established disorders, but gradually the emphasis must shift to a preventive approach. Within this new, more comprehensive framework for understanding, coping with, and preventing disordered human behavior, community development as a primary preventive intervention can play an important role.

Emphasizing primary preventive intervention as the community development strategy most applicable to the problem of mental illness, one is more concerned with treatment, and pre-treatment stages, than with rehabilitation efforts. There is a concern with the total community rather than primarily or exclusively with the individual. At the same time, the fact that communities are organized and that this community organization is a powerful and relevant force in the service of improving the community's emotional well-being, can be recognized and utilized. It follows that closer attention must be paid to the working with and through community agencies.

By primary prevention of mental illness thus is meant such measures and activities which will reduce the number of cases of disorder in the community as well as effectively prevent the occurrence of new cases.

The American Public Health Association stated the following:

> Prevention may be accomplished in the pathogenesis period by measures designed to promote general optimum health or by specific protection of a man against disease agents or the establishment of barriers against agents in the environment.
>
> (Program Area Committee, 1962)

Accepting this as a basic definition it can be seen that the approach, as also in public health efforts with general disease, considers the cause of disease in three categories:

(1) the host, i.e. the individual or group of individuals (population at risk) susceptible to the disease,

(2) the agent, i.e. the major factor necessary for the occurrence of the disease, characterizing the disease, and serving as the label (e.g. from general disease: diphteria bacillus), and

(3) the environment, i.e. the collection of all the external factors surrounding the host with the exception of the agent.

In public health psychiatry, and in community mental health, the agent is unknown, though some kind of stress has frequently been suggested. The community mental health approach basically assumes that mental illness does not exist in the person, but in the interaction among an individual, his social group, and everything else around him. Thus it is generally accepted that social crippling often is a by-product of the social experiences and deprivations to which the mentally ill are commonly subjected (USDHEW, 1962). As no specific agent, or cause, is known, primary prevention must aim at changes in the individual or the population at risk, and at changes in the environment in an attempt at promoting general optimum mental health (also suggested by Leavell and Clark, 1965). Thus in fact one must seek to understand preventive intervention as falling into two categories, i.e. one that is people-centered, and one that is system-centered.

In the people-centered category one would place such approaches as consultation, crisis intervention, and those focusing on early childhood and young persons. In the system-centered category one would find approaches emphasizing the family and the school, as well as socio-cultural settings generally.

People-centered preventive approaches

Approaches in this category will be seen mainly to deal with existing disorders and seek to prevent future ones by attempting to mobilize and activate already existing and available resources in an optimum effective mental health delivery system. This involves coming to grips with the present professional shortages of manpower. As many approaches call for innovative use of manpower, it appears that much of current effort can more successfully be achieved through the use of non-professionals in the mental health field. This envisaged need for an increasing use of non-professionals is in direct agreement with community development principles. Recently many authors have addressed themselves to this issue (e.g. Cowen, 1967; Reiff, 1967; Arnhoff, Rubinstein and Speisman, 1969; Grosser, henrry and Kelly, 1969; Sobey, 1970; and Gartner, 1971). Further a need for change in the role of the professional to become more a resource person, a supervisor of non-professionals, and a consultant, can be seen. Again the professional may serve as a liaison person between various agencies; he may be involved in administrative, organizational and political work related to the field of mental health. To this end it will be necessary to modify training of professionals to enable them to better perform such new functions (Goldston, 1965; Iscoe and Spielberger, 1970).

Haylett and Rapoport (1964) defined consultation as being a process whereby mental health professionals try to help less knowledgeable contact persons to deal with psychological problems. That a need exists for greater emphasis on consultation can be seen from Gurin, Veroff and Feld (1960) who report that referral to mental health professionals were fewer than twenty per cent. They stated that the largest number of requests for help were directed to clergymen (42 per cent), and to family physicians (29 per cent). The present study did not replicate these results, as here the mandated mental health professionals, i.e. psychiatry, psychology, and social work received the largest referral. Thus referrals to private psychiatrists for disturbed persons in ten descriptions amounted to 24.71 per cent, to family physicians - 19.61 per cent. Referrals to clergy amounted to only 2.16 per cent. Private psychiatrists, family physicians, and the provincial mental hospital together received 52.75 per cent of total referrals.

Mental health consultation rests on several assumptions. Thus it is assumed that resources are insufficient to meet needs, and that early intervention can be more effective than late intervention. One aim of the community development intervention is to assist the community in producing and in finding more useful resources from within itself in order to meet existing needs, and to provide or stimulate an early and positive intervention. Thus the community development agent will find a ready role for himself within a mental health consultation approach. It is further assumed that it is better (more effective) to focus our efforts on promoting mental health, rather than seek to fight and patch-up the ravages of so-called mental illness that has been present for some time. This naturally is not to say that we should no longer exert any effort in the areas of secondary, and tertiary prevention, only that it is seen as necessary and more productive to shift our focus of attention unto the area of primary prevention. As it is assumed that psychological problems are interwoven with other complex problems of living, one can again see the prominent role that can be filled by the community development agent. As a generalist, the community development agent will concern himself with many of the complex problems of living in the community that are possible factors in causation of the incidence of mental illness, such as poverty, housing, education, employment, nutrition, bereavement, and old age, etc. Because of his training as a generalist, he is specially suited for the role of consultant. Further, as many complex problems of living are brought to people, who are not professionally trained to deal with them, and as it is precisely with such people, the community development agent most frequently finds himself involved, he may be especially valuable in the consultative role.

Lindeman(1944), and Caplan(1964) talked about physicians, clergymen, educators, and lawyers as caregivers to whom consultation would be a valuable preventive intervention. As professionals these would easily be known to mental health planners and administrators. Somewhat in contrast to these and much less identifiable and accessible to mental health professionals, but no doubt more obvious and more accessible to the community development agent, are such groups of direct importance to the community, as for example cab drivers, bartenders, hairdressers, policemen, shopowners, etc. These have been mentioned by Kelly (1964) as urban agents. For these groups consultation may be most easily and effectively available from a community development agent. Frequently such an agent may find himself in rural areas, small urban centers, or in geographically isolated regions with low population density, which generally are lacking in mental health services and personnel. The efforts of a community development agent providing consultation to non-professionals in such areas assumes great importance for the local communities (Robinson, DeMarche and Wagle, 1961). Examples of consultation programs in areas lacking mental health services have been given by several authors (e.g. Huessy, 1966; Spielberger, 1967; Griffith and Libo, 1968; and Kiesler, 1969).

Perhaps one of the most important ways in which consultation can be used by the community development agent, is in its application toward the engineering of social environments. With his training in community development the agent would be in a strong position to advise about social environments, and encourage the community to develop such environments that would favor sound psychological development and prevent dysfunction. He will be able to assist the community in discovering how social environments within the community relate to psychological development, and how they can be modified (Kelly, 1970; Trickett, Kelly, and Todd, 1971). Behavioral engineering approaches in general could have much potential. Thus Sarson and Ganzer (1969) describe the use of social reinforcement techniques for modifying behavior of the individual community member, and various consultative roles, that could readily become part of the community development agent's repertoire. Such behavior modification techniques furthermore are easily learned and utilized by people without any special training. A more full participation by the member of the community can thus be made possible. This could ensure the early detection of dysfunction, and in this way consultation can be seen to support and strengthen effective crisis intervention, which could often be done by caregivers and urban agents (Singh, Tarnover, and Chen, 1971).

Crisis intervention as a preventive approach has been discussed previously in this study. Only a further few remarks will then be made at this point. Since Lindeman's (1944) study much has been written about crisis intervention and its significance and importance for maintaining positive mental health in the community (e.g. Caplan, 1964; Specter and Claiborn, 1973; McGee, 1974). Though crisis intervention is an intervention with individuals, the community development agent could still have a role to play in its use as a training technique. Cumming and Cumming (1966) suggested the use of crisis intervention as a training technique by presenting controlled crisis-resolution exercises under sheltered conditions and with positive outcome to members of the community. They suggest that the ego strength of the individual would increase even for community members under severe environmental stress. This is similar to the anticipatory guidance or emotional innoculation suggested by Caplan (1965).

An important approach within the category of people-centered preventive intervention is the one focusing on early childhood and young persons. It is generally assumed that the best time at which to attempt preventive intervention is before any manifest signs of psychosocial disturbance are evident. The earlier the intervention takes place, the higher the potential effectiveness. Thus it is assumed that a focus on early childhood is especially profitable; that the young child is indeed more flexible and easier to shape than is the adult. Early childhood is seen as a period of maximal potential for the modifiability of the organism (Eisenberg, 1962, a,b). The young child has not yet learned maladaptive behaviors that later must be discarded, and thus intervention may be seen as especially effective in childhood (Bloom, 1964). Again, it has been suggested that there are critical periods during which various types of responses may be acquired and during which facilitative experiences are desirable. To provide such experiences, or "supplies" in Caplan's (1964) term when they are needed is positive primary prevention.

As with all primary prevention efforts in mental health, the early childhood approach offers serious and complex difficulties. The specific environmental antecedents of psychological dysfunction is not known for most disorders. Most attempts, therefore, have been aimed at rather conservative goals. Thus for example Biber (1961) concerned with teacher education methods and primary prevention in the classroom set the following interlocking goals for preventive mental health:

(1) positive feeling toward self,
(2) realistic perception of self and others,
(3) relatedness to people,
(4) relatedness to environment,
(5) independence,
(6) curiosity and creativity, and
(7) recovery and coping strength.

Others similarly have set goals involving particularly the enhancement of cognitive development, suggesting that unfavorable environments interfering with full cognitive growth, may produce dull, unmotivated, and eventually deficient persons (Hunt, 1961). The importance of the focus on early childhood needs was emphasized by Smith and Hobbs (1966), who suggested that fully half of all our mental health resources should go to work with children:

> This would be the preferable course even if the remaining 50 % were to permit only a holding action with respect to problems of adults.
>
> (p. 505)

In support of this, Glidewell and Swallow (1969) found that thirty per cent of all elementary school children have school adjustment problems. For ten per cent of the school population these were found to be severe enough to require immediate professional help. However, in order to ensure effective utilization of resources, it must be asked whether early detected childhood dysfunctions remain stable so that they, untreated, result in later adult dysfunction, or mental illness? Answers to this question have been conflicting.

There are studies presenting pessimistic conclusions, pointing to the collective failures of child-guidance clinics, and suggesting that treatment of children is less effective than similar work with adults. It has been argued that psychotherapy's effectiveness for adults has yet to be demonstrated (Eysenck, 1952), and this was extended to the outcome of work with children by Levitt (1957) surveying the effectiveness of psychotherapy with children. Results of such therapy have not been particularly encouraging (Levitt, 1963, 1971). The Joint Commission report (1961) even goes so far as stating that child treatment is largely ineffective:

> Our hopes of preventing mental illness by mental health education and child guidance clinics have been disappointed, and there is no convincing evidence that anyone has ever been kept out of the state hospital by such measures.
>
> (p. 71)

Further, there are many who will suggest that emotional problems of children are ephemeral and transitory, and cannot be used as reliable indicators of subsequent psychological difficulties in adult life (Allinsmith and Goethals, 1962). Nevertheless, there are indications, especially from follow-up studies of children seen in clinics, indicating that the early problems are persisting. In a very comprehensive study, covering a thirty-year span, O'Neal and Robbins (1958 a,b) followed up a group of subjects first seen in the mid 1920's for some type of problem behavior. It was found that about sixty per cent displayed various forms of pathological and antisocial, disturbed behavior. It is stated that this was three times as high an incidence figure as found in the control group. Similarly, Robbins (1966) indicated the relationship between childhood disorder and later maladjustment in the adult as being markedly positively correlated. Bower (1963) observed that a group of children with moderate to severe emotional problems did not over a period of several years self-correct, but rather were seen to have fallen even further behind their peers. There are thus clear indications that effort in early childhood is required if we desire less "mental illness" in the community. Early intervention is vital. For the community development agent such intervention may be directly with children or with those adults, parents and other, who are concerned with the welfare of the children in the community. Though there are indications that early childhood problems can be significant danger signs for the future, more research is needed. Such research may possibly find a profitable area in the study of shaping-settings and systems, an area familiar and of interest to the community development agent, and in which his particular skills may contribute positively to the future of the community.

Both the family and the school are social systems within which much of the growth and psychological development of the prospective member of the community take place. Thus, as we seek to develop the psychological sense of community, and to greatly reduce if not totally eradicate mental disorder, we must turn to a consideration of the primary prevention approach within social systems.

Social system-centered preventive approaches

People-oriented approaches are important, and a continuing need exists for these. The very real progress that can be and is being made in these areas must be accepted and acknowledged. However, in order to really come to grips with the problem of mental health and mental illness in the community, it is necessary to draw on the concept of a system. By this is understood a concern with the notion that social systems and their problems are interrelated. A concern with understanding and mocifying social systems for the purpose of preventing emotional and behavior disorders, becomes essential.

For the community development agent it is here that the challenge and opportunity of the present trend is found. Though possibly skilled in various types of person-oriented approaches, dealing with the social system is more directly the approach of the community development agent, as he sees the social life of people as a whole, as a functional unity, as community. He is more concerned with a particular whole or system, than with the individual member of that system. In this he is not only adhering to community development principles, but following the retreat from the atomistic and mechanistic approach of the nineteenth century toward a holistic image of reality.

For the human being living his entire life within the social matrix of the community, the social systems of this matrix, and their interaction contexts are important. It is these and his reciprocity with these that largely determine the development and state of mental health of the community member. It is, therefore, vitally important for the community development agent, interested in utilizing mental health issues for the purpose of developing and strengthening a psychological sense of community, to have a clearer understanding of how social systems affect the community member in basic ways (Barker and Gump, 1964; Barker and Schoggen, 1973). He needs to know the influential dimensions of social environments, and to be able to adapt such to the greatly varying individual differences in community members (Moos, 1973; Insel and Moos, 1974). Sarason (1972) for example has pointed out that we must learn to create or engineer settings that will produce positive outcome for the psychological well-being of the community members. This also was a main concern and suggestion in much of B. F. Skinner's work. Similarly Fairweather (1967) proposed "experimental social innovation" as one of the most urgent social needs. In his work, he describes steps for such innovation, which is aimed primarily at such systems as mental hospitals, schools, and prisons:

(1) the first step is to define a significant social problem,

(2) then to identify the factors related to the problem's occurrence in a natural context, and to formulate alternatives for resolving it, followed by

(3) an experiment comparing alternative approaches.

Fairweather (1967) states that such experimentation must be attempted before any alternative approach can be suggested for adoption and implementation by the community members. This is in contrast to Caplan (1964) who assumes that his social-action proposals for primary prevention are acceptable and of value without such prior experimentation. It may be suggested that in this the community development agent may best achieve his objectives by utilizing Fairweather's approach.

The social-system centered approaches, as the person-centered ones, emphasize prevention within the family and the school. However, the community development agent will go beyond these systems in his efforts, unto such areas as the political and legal fields, broadening out from a concern with the individual to larger social groups, industrial organizations, entire nations and cultural groups, eventually to encompass the planetary family of man. Indeed, boundaries between various systems, e.g. mental health, education, politico-legal, welfare systems, etc., are already at present increasingly difficult to define. Not only the interorganizational relationships are becoming blurred, but the boundaries between these systems and the environment, between sub-systems and supra-systems have begun to lose meaning and reality. This requires intensive attention to the question of reciprocity, which can be seen as a precondition for the continuance of the community (Malinowski, 1926; Gouldner, 1959). This also means that special attention must be given, and allowance must be made for the process of feedback in all interventions and program approaches contemplated by the community development agent, and implemented by the community members. Thus, much effort is needed with regard to possible techniques and designs of evaluation. There must be in all preventive efforts a sincere committment to extending the knowledge basis for community interventions. This can best be done via feedback, and the use of approaches similar to the "experimental social innovation" as proposed by Fairweather (1969).

Though preventive efforts have been contemplated in areas throughout community life, probably most of the effort has been focused on the school and the family system. It is realized that both of these systems, being key socializing agencies, have powerful impact on the psychological development of community members. Of these, intervention has been easier to implement within the school system. Then again, as pointed out by Cowen (1967) schools are frequently good entry points for establishing family contacts.

Schools

Sarason (1972) suggests a need for changing the social processes of schools in order to make them better environments for emotional growth. Thus the intention of preventive intervention in the school system is to create an educational setting more productive of personality development (e.g. Allinsmith and Goethals, 1962; Bower and Hollister, 1967). Again, the setting of the school system has attracted interest. Thus a search for key dimensions of the setting having definite impact on the mental health of the child has been taken up (e.g. Sarason, 1971; Michael, 1968; Trickett and Moos, 1973, 1974). It is, however, not only the physical aspects of the setting nor just the social aspects of the environment that affects the positive mental health of the student. The learning atmosphere and the teaching approach utilized by the teachers has long-range impact on the children. Zimiles (1967), and Minuchin et al. (1969) found, in their studies, differences among students in terms of differentiated self-perceptions, independence in thinking, etc. as a result of exposure to a modern versus a traditional educational approach. This suggests a need for alerting school staff to the needs of individuals. If such intervention is to be successful, there must be an intensive information feed-back to both staff and children. This must involve a development of social interaction and provide opportunities for social reinforcement and social modeling, as well as a deliberate environmental manipulation.

Such environmental manipulation emerges in writings by Kelly (1966, 1968, 1969, 1971), and by Trickett et al. (1971), who argue in favor of an ecological approach. This approach emphasizes a focus on the interrelation of social or organizational systems in the community, on the relation between the physical environment and individual behavior, and on the relation of the individual to his immediate social environment. The studies by Kelly (1968, 1969) within two high schools in Columbus, Ohio, with different environments are especially interesting in that they illustrate the value of simultaneous investigations of qualities, not only in the individual, but also in the environment. Such investigations lead to a better understanding of conditions under which disturbed behavior occurs. They also indicate under which conditions adaptive behaviors occur. The implication is that mental health problems differ according to the environmental setting, and preventive interventions must thus be differently conceived for each environment. Though the concern with the interrelation of social or organizational systems in the community most often has been one for those concerned with business and industrial organizations, its relevance for the school system and for the field of mental health is now becoming better understood (Kahn, 1968).

Changes in the school curriculum to better suit and promote childrens' psychological strengths and mental health have been suggested as a valuable preventive measure by some (e.g. Roen, 1967; Ojeman, 1969). Finally must be mentioned efforts by an ever increasing number of professionals within behavior modification (e.g. Woody, 1969; MacMillan, 1973) as a significant and highly effective preventive intervention. An interesting and valuable paper on behavioral prevention has been offered by Ernest G. Poser (1976). Though still to a large extent dealing with individuals, techniques discussed could likely be utilized for social system intervention. Poser discusses latent inhibition which, however, requires a knowledge of stimuli implicated in a maladaptive conditioning process. Further, anticipatory modification, coping models using modeling and observational learning, are considered. Finally, as a necessity for identifying populations at risk, Poser discusses various attempts at developing a screening test battery, which could make it possible to select appropriate methods of preventive intervention. The paper also provides a useful list of references.

Family

There can be no doubt about the importance of the family for mental health. Thus for example Langsley et al. (1971) demonstrated that a family approach in mental health can prevent hospitalization in approximately 80 per cent of cases. Furthermore, they pointed out that the ultimate cost would be only one sixth that of hospitalization.

The family is the effective intimate social environment for individuals preparing them for entry into the larger social system of the community. However, with the present emphasis on deviant aspects, disturbed individuals, or isolated family processes, insufficient attention has been paid to sources of psychological strength and competence within the family.

There now exists an extensive literature on family therapy. Thus Glick and Haley (1971) list approximately 2,000 books and papers. Most of these, nevertheless, emphasize and deal with either isolated aspects of the family or with so-called pathological families. Recently the process of conjoint family therapy (Satir, 1967, 1972) has focused on the total family, though still largely in terms of a therapy pattern. A pioneering investigation of the complete family in its natural setting was undertaken for the first time by Kantor and Lehr (1975). They produced a systematic framework that can be used to analyse all major features of family life. Thus it can be used to assist community development agents to shape their interventions to different families before the emergence of any pathological features, focusing on strengths and on the dynamics of the family as a system. This kind of thinking does have an earlier representative in Jules Henry (1964) who suggested that:

> Direct observation of families functioning in their native habitats should be the microscope that reveals new phenomena of family existence and so provides the possibilities of new theory.
>
> (p. 31)

Again, Jacob's (1975) comprehensive review of interaction patterns in normal and disturbed families may be of great value for the community development agent concerned with mental health issues.

Though the family is a system more difficult to enter with preventive community development intervention, than is the school system, it is not presenting an impossible task. Premarital and sexual counselling by the family physician and by clergymen provides another valuable entry point for the community development agent. Thus for example, the hotel keeper's interest and concern for honeymoon couples (Rapoport and Rapoport, 1964) can be utilized with a great measure of success. Contacts within pregnancy- and well-baby clinics can be excellent entry points. An extensive use of the community's caregivers and urban agents must be encouraged. It may well be that the professional in mental health does not have the power to bring about desired social changes (Dunham 1965, p. 306), but the community development agent has been trained for planning and organizing for social change, and should be in a position to aid the community to move toward a more healthy state.

At times the family can be reached for primary preventive interventions via the police or probation departments. Even the peer group, especially when dealing with adolescents, may be considered. The peer group is a primary socializing agency, and proper utilization may provide entry to individual families (e.g. Speck and Attenave, 1971; Soskin, Ross, and Korchin, 1971).

The importance of the family cannot be in doubt, and its importance for the future community (society), the importance of the process of communication, feedback, etc. - all part of the community development agent's tools, has been stated by for example Satir (1972):

> Families and societies are small and large versions of one another. They are both made up of people who have to work together, whose destinies are tied up with one another.
>
> (page 290)

> ... now put these powerful forces to work in your family. And when they start to function in your family, making it a more nurturing one, these same kind of forces will be applied in society. It could even be the beginning for a new kind of society. After all, the family unit is the synthesizing link to its parent - society as a whole.
>
> (page 297)

Future Trends

Looking toward the future, trends in community approaches to the problem of mental illness can be anticipated at least in general outlines. Though mainly concerning the field of mental health, future trends must be seen, if possible, against the background of a more wide-reaching speculation as to the general future of man.

As a psychological sense of community is developed and strengthened, the community will begin more consciously to accept its responsibility for its members, their well-being, and future usefulness to the community, and to mankind.

Emphasis in the mental health field may be seen to shift from treatment and rehabilitation efforts to a concern with primary prevention. Community members will, in addition to interventions with the individual, become concerned with the impact that influential environments and settings have on people. Instead of excessive focus on pathology, there will be an active search for new ways of enhancing psychological competence. There will be a focus on the psychological strengths and resources of persons, and on social system modification as a way of optimizing psychological development of the community members.

Increasingly a discovery (or rediscovery) of the communitas of people will be realized. Persons linked to persons, and part of nature (environment), not separate from it, will refashion a psychological sense of community. Thus there will be a move toward the recreation of community, an interdependency with others, and, therefore, an increased realization of reciprocal responsibility. A change from short-term planning to efforts in the direction of long-range planning will assert itself, and contribute to a sense of belonging, rootedness, and sharing. Long-range planning as problem solving through understanding of dynamic relationships between several relevant variables thus implying social control over future events must be undertaken. This requires that we learn to live with and acknowledge great uncertainty, and accept the ethical responsibility that attends social goal setting.

Each community member must realize that each one is unavoidably linked to and dependent on each other member of the community. Given this mutual dependence, it must be realized that we must seek to create a future conducive to optimal development of the person's psychological strengths and potential.

Greater emphasis will be placed on preventive interventions with the family system. This will require more attention to analysis of processes and dynamics of family interactions. Research to unveil the major themes and components of family processes that strongly influence family members in such a way as to strengthen their potential for a mentally healthy and productive development must be undertaken. Behavior modification techniques will become more readily utilized for influencing child rearing and parent education. This will promote greater understanding of the complexities of growth and maturational development. Premarital and antenatal consultation and counselling will be increasingly utilized. The understanding that disordered behavior reflects important environmental stresses will lead to careful environmental manipulation and modification in the home-setting as well as in the community generally.

Within the school system changes in the school setting itself, in the curriculum, and in the teaching approaches will be made. Behavior modification techniques will be found eminently suited to primary prevention in school settings. Utilization of school students as non-professional workers within the community mental health system will become common-place.

Application of behavioral technology to all areas of community life can be made with a view to ameliorate or potentially solving social problems of varying severity. Utilization of environmental manipulation and social control will increase with an understanding of the continuous reciprocal interaction between the community members and the community environment, and the resulting behavior of the persons.

Already the community is becoming intensively involved in providing community care for those members who have been found to suffer from emotional and behavior disorder. Thus for these individuals there will be a continued effort to provide improved care within the community. Education programs will be offered in compatible centers, not limited to cater for those already disturbed, but providing a meeting-place for community members in general. Such community mental health centers would provide training in social interaction, social skills, socialization experiences, and education for increased realization of human potential. Emphasis would be on health, on psychological strengths and problem solving behavior rather than on pathology. Increased efforts within service components as previously discussed on pages 127 - 141 of this study, will take place.

Use of batteries of tests for the purpose of discovering populations at risk, malfunctioning accommodation between areas of the social system and its population, and lack of intersystem accommodation must be encouraged. Increased utilization also of social indicators will take place, and interdisciplinary research in all areas of concern for the development of psychologically strong and resourceful individuals will be undertaken. Evaluation research, as well as a continuous monitoring via feedback systems will be utilized in connection with all primary preventive interventions. Again, programs will be developed, aimed at influencing the community through consultation to its various institutions.

Closer and more dynamic interaction must take place between the smaller community and a central government, including more liberal funding from government to research, and the establishing of primary prevention projects. More effective and direct communication and cooperation between government, agencies and individuals will encourage greater and more efficient citizen participation.

The real challenge for the community development agent lies in the fact that this move, that these new directions in the field of mental health, may make it possible for him to develop and strengthen a psychological sense of community. This may provide for the first time in the history of man a real potential for beginning to develop his nature fully, and to create such social arrangements as will allow for optimal exploration and understanding of his real potential for development.

The community development strategy of primary preventive intervention will ensure the opportunity for a more human definition of social reality, and for the emergence of a functional planetary community of man.

BIBLIOGRAPHY

ABRAMOVITZ, A. B., Methods and techniques of consultation, *American Journal of Orthopsychiatry*, 1958, *28*, 126 - 133

ADAMS, Henry B., "Mental Illness" or interpersonal behavior, *American Psychologist*, 1964, *19*, 191 - 197

ADELSON, D., A concept of comprehensive community mental health, in ADELSON, D., & KALIS, B.L., (eds.), *Community psychology and mental health: Perspectives and challenges*, San Francisco: Chandler, 1970

ADELSON, D., & LURIE, Lawrence., Mental health education: Research and practice, in GOLANN, S.E. & EISDORFER, C., (eds.), *Handbook of community mental health*, New York: Appleton-Century-Crofts, 1972

ADORNO, T. W., FRAENKEL-BRUNSWICK, E., LEVINSON, D. J., & SANFORD, R N., *The authoritarian personality*, New York: Harper, 1950

ALBEE, G. W., Manpower needs for mental health and the role of psychology, *Canadian Psychologist*, 1965, *6*, 82 - 92

ALBEE, G. W., The relation of conceptual models to manpower needs, in, COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.), *Emergent approaches to mental health problems*, New York: Appleton-Century-Crofts, 1967, pp. 63 - 73

ALBERTA HEALTH AND SOCIAL DEVELOPMENT, *Perceptions of mental health - the citizens point of view*, Edmonton: Decision Making Information Canada, Ltd., 1974

ALINSKY, Saul D., *Reveille for radicals*, Chicago: University of Chicago Press, 1946

ALLINSMITH, W., & GOETHALS, G. W., *The role of schools in mental health*, New York: Basic Books, 1962

ARENSBERG, Conrad M., & KIMBALL, S. T., *Culture and community*, New York: Harcourt, Brace and World, Inc., 1965

ARGYRIS, Chris., *Intervention theory and method, a behavioral science view*, Reading, Mass.: Addison-Wesley Publishing Company, 1970

ARMOR, D. J., & KLERMAN, G. L., Psychiatric treatment orientations and professional ideology, *Journal of Health and Social Behavior*, 1968, *9*, 243 - 255

ARNHOFF, F. N., RUBINSTEIN, E. A., & SPEISMAN, J. C., *Manpower for mental health*, Chicago: Aldine, 1969

AUSUBEL, David P., Personality disorder is disease, *American Psychologist*, 1961, *16*, 69 - 74

AVIRAM, Uri., Exclusion of the mentally ill, *Archives of General Psychiatry*, 1973, *29*, 126 - 131

BABBIE, Earl R., *Survey research methods*, Belmont, Calif.: Wadsworth Publishing Company, Inc., 1973

von BAEYER, W., Die Verantwertung der Gesellschaft für ihre psychish Kranken, *Social Psychiatry*, 1966, *1*, 2 - 6

BAKER, F., From community mental health to human service ideology, *American Journal of Public Health*, 1974, *64*, 576 - 581

BAKER, Frank., & SCHULBERG, Herbert C., The development of a community mental health ideology scale, *Community Mental Health Journal*, 1967, *3*, 216 - 225

BAKER, F., & SCHULBERG, H. C., Community mental health ideology, dogmatism, and political-economic conservatism, *Community Mental Health Journal*, 1969, *5*, 433 - 436

BANDLER, B., The american psychoanalytic association and community psychiatry, *American Journal of Psychiatry*, 1968, *124*, 1031 - 1042

BANDURA, Albert., *Principles of behavior modification*, New York: Holt, Rinehart and Winston, Inc., 1969

BARKER, R. G., (ed.), *The stream of behavior*, New York: Appleton-Century-Crofts, 1963

BARKER, R. G., *Ecological psychology*, Stanford, Calif.: Stanford University Press, 1968

BARKER, R. G., & GUMP, P., *Big school, small school*, Stanford, Calif.,: Stanford University Press, 1964

BARKER, R. G., & SCHOGGEN, P., *Qualities of community life*, San Francisco: Jossey-Bass, 1973

BARRETT, J. J., KURIANSKY, J., & GURLAND, B., Community tenure following emergency discharge,
American Journal of Psychiatry, 1972, *128*, 958 - 964

BARTON, R., *Institutional neurosis*,
Bristol, U.K.: John Wright and Sons, Ltd., 1959

BECKER, Alvin., & SCHULBERG, H. C., Phasing out state hospitals - a psychiatric dilemma,
The New England Journal of Medicine, 1976, *294*, 255 - 261

BEERS, C., *A mind that found itself*,
New York: Doubleday Doran, 1908

BELLAK, Leopold., A genral hospital as a focus of community psychiatry,
J.A.M.A., 1960, *174*, 2214

BELLAK, L., Community psychiatry: The third psychiatry revolution, in BELLAK, L., (ed.), *Handbook of community psychiatry and community mental health*,
New York: Grune & Stratton, 1964

BELLAK, L., & SMALL, Leonard., *Emergency psychotherapy and brief psychotherapy*,
New York: Grune & Stratton, Inc., 1965

BELSON, W. A., *The hurt mind: An enquiry into some of the effects of the television series "The hurt mind"*,
London: Audience Research Department, BBC, 1957 (a)

BELSON, W. A., The ideas of the television public about mental illness,
Mental Health, 1957 (b), *16*, 95

BENEDICT, R., *Patterns of culture*,
Boston: Houghton Mifflin, 1934

BENEDICT, R., Anthropology and the abnormal,
Journal of General Psychology, 1934, *10*, 59 - 82

BENNETT, C. C., ANDERSON, L. S., COOPER, S., HASSOL, L., KLEIN, D. C., & ROSENBLUM, A., *Community psychology: A report of the Boston conference on the education of psychologists for community mental health*,
Boston: Boston University Press, 1966

BENNIS, W. G., BENNE, K.D., & CHIN, R., (eds.), *The planning of change: Readings in the applied behavioral sciences*,
New York: Holt, Rinehart & Winston, 1962

BERLIN, I. N., Some learning experiences as psychiatric consultant in the schools,
Mental Hygiene, 1956, 40, 215 - 236

BERLIN, I. N., The theme in mental health consultant sessions,
American Journal of Orthopsychiatry, 1960, 30, 827 - 882

BERLIN, I. N., Learning mental health consultation: History and problems,
Mental Hygiene, 1964, 48, 257 - 266

BERNARD, Jessie., The sociology of community,
Glenview, Ill.: Scott, Foresman and Company, 1973

BIBER, B., Integration of mental health principles in the school setting, in CAPLAN, G., (ed.), Prevention of mental disorders in children,
New York: Basic Books, 1961, pp. 323 - 352

BIDDLE, W. W., The "fuzziness" of definition of community development,
Community Development Journal, 1966, 2, p. 12

BINDMAN, A. J., Mental health consultation: Theory and practice,
Journal of Consulting Psychology, 1959, 23, 473 - 482

BINDMAN, A. J., & SPIEGEL, A. D., (eds.), Perspectives in community mental health,
Chicago: Aldine Publishing Co., 1969

BLAIR, W., Mental health in Alberta,
Edmonton: Queens Printer, 1969

BLOCK, W. E., The study of attitudes about mental health in the community mental health center,
Community Mental Health Journal, 1974, 10, 216 - 220

BLOOM, B. S., Stability and change in human characteristic,
New York: Wiley, 1964

BLOOM, S. W., The doctor and his patient,
New York: Russell Sage Foundation, 1963

BOAS, F., Mind of primitive man,
New York: Macmillan, 1919

BOCKOVEN, J. S., Moral treatment in American psychiatry,
Journal of Nervous and Mental Diseases, 1956, 124, 167 - 194, 292 - 321

BOWER, E. M., Primary prevention of emotional disorders: A conceptual framework and action possibilities, *American Journal of Orthopsychiatry*, 1963, *33*, 832 - 848

BOWER, E. M., & HOLLISTER, W. G., (eds.), *Behavioral science frontiers in education*,
New York: Wiley, 1967

BRAGINSKY, B. M., BRAGINSKY, D. D., & RING, K., *Methods of madness: The mental hospital as a last resort*,
New York: Holt, Rinehart, & Winston, 1969

BROWN, B.S., Philosophy and scope of extended clinic activities, in BINDMAN, A. J., & SPIEGEL, A. D., (eds.), *Perspectives in community mental health*,
Chicago: Aldine Publishing Co., 1969, pp. 41 - 53

BROWN, G., BONE, M, DALISON, B., & WING, J., *Schizophrenia and social care*,
London: Oxford University Press, 1966

BURROWS, W. G., Community psychiatry - another bandwagon? *Canadian Psychiatric Association Journal*, 1969, *14*, 105 - 114

CAFFEY, E. M., GALBRECHT, C. R., & KLETT, C. J., Brief hospitalization and aftercare in the treatment of schizophrenia, *Archives of General Psychiatry*, 1971, *24*, 81 - 86

CANADIAN MENTAL HEALTH, 1965, Nov. - Dec., page 3

Canadian Mental Health Association, 1963 - v. TYHURST, J. S.

CANADA MENTAL HEALTH ASSOCIATION, QUEBEC, *A survey*, Nov. 1974

CAPLAN, G., *Concepts of mental health and consultation: Their application in public health social work*,
Washington, D. C.: U.S. Dept. of Health, Education, and Welfare, 1959

CAPLAN, G., *An approach to community mental health*,
New York: Grune & Stratton, Inc., 1961

CAPLAN, G., *Principles of preventive psychiatry*,
New York: Basic Books, 1964

CAPLAN, G., Opportunities for school psychologists in primary prevention of emotional disorders of children, in, LAMBERT, N. M., (ed.): *The protection and promotion of mental health in schools*,
Bethesda, Md.: U.S. Dept. of Health, Education, and Welfare, Public Health Service Publication, No. 1226, 1965, pp. 9 - 22

CAPLAN, G., *The theory and practice of mental health consultation*, New York: Basic Books, 1970

CAPLAN, R., *Psychiatry and the community in nineteenth century America*, New Yor: Basic Books, 1969

de CAROZZO, G. C., Ein Versuch zur Erforschung der Einstellungen gegenüber psychisch Kranken, *Social Psychiatry*, 1971, *6*, 36 - 39

CARSTAIRS, G. M., Preventive psychiatry - is there such a thing?, *British Journal of Psychiatry*, 1958, *104*, 63

CHIEN, C., & COLE, J. O., Landlord supervised cooperative apartments: A new modality for community based treatment, *American Journal of Psychiatry*, 1973, *130*, 156 - 159

CHIN, R., Basic strategies and procedures in effecting change, in MORPHET, E. L., & RYAN, C. O., (eds.), *Planning and effecting needed changes in education*, Denver: Publishers Press, 1967

CHIN, R., & BENNE, K., General strategies for effecting change in human systems, in BENNIS, W. G., BENNE, K., & CHIN, R. (eds.), *The planning of change*, New York: Holt, Rinehart & Winston, 1962

CHIN-SHONG, E., Rejection of the mentally ill: A comparison with the findings on ethnic prejudice, (unpublished Ph.D. dissertation), New York, N. Y.: Columbia University, 1968

CLARK, T. N., *Community structure and decision-making: comparative analysis*, New York: Chandler Publishing Company, 1968

CLAUSEN, J. A., A sociological perspective, in BROCKBANK, R., & WESTBY-GIBSON, D., (eds.), *Mental health in a changing community*, New York: Grune & Stratton, Inc., 1966, pp. 13 - 17

CLAUSEN, J. A., Mental disorders, in MERTON, R. K., & NISBET, R. A., (eds.), *Contemporary social problems*, 2nd. ed., pp. 26 - 83 New York: Harcourt Brace Jovanovich, 1966

CLAYHORN, J. L., & KINROSS-WRIGHT, J., Reduction in hospitalization of schizophrenics, *American Journal of Psychiatry*, 1971, *128*, 344 - 348

COHEN, J., & STRUENING, E. L., Opinions about mental illness in the personnel of two large mental hospitals, *Journal of Abnormal and Social Psychology*, 1962, *64*, 349 - 360

COLEMAN, J. V., Psychiatric consultation in casework agencies, *American Journal of Orthopsychiatry*, 1947, *17*, 533 - 539

CONRAD, K., Das Problem der 'nosologischen einheit', *Der Psychiatrie Nervenartz*, 1959, *30*, 488 - 494

COOK, S. W., & SELLTIZ, Claire., A multiple-indicator approach to attitude measurement, *Psychological Bulletin*, 1964, *62*, 36 - 55

COSTELLO, C. G., Classification and psychopathology, in COSTELLO, C. G., (ed.), *Symptoms of psychopathology: A handbook*, New York: John Wiley and Sons, Inc., 1970, pp. 1 - 26

COWEN, E. L., Emergent approaches to mental health problems: an overview and directions for future work, in COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.), *Emergent approaches to mental health problems*, New York: Appleton-Century-Crofts, 1967, pp. 389 - 455

COWEN, E. L., & ZAX, M., Th emental health fields today: Issues and problems, in COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.), *Emergent approaches to mental health problems*, New York: Appleton-Century-Crofts, 1967, pp. 3 - 29

CRAWFORD, E., ROWLEY, D., & ROWLEY, C., Mental hospitals - an obituary, *Journal of Psychiatric Nursing and Mental Health Services*, August, 1971

CROCETTI, G. M., & LEMKAU, P. V., Public opinion of psychiatric home care in an urban area, *American Journal of Public Health*, 1963, *53*, 409 - 414

CROCETTI, G. M., SPIRO, H. R., LEMKAU, P.V., & SIASSI, I., Multiple models and mental illnesses: A rejoinder to "Failure of a moral enterprise: Attitudes of the public toward mental illness" by T.R. Sarbin and J.C. Mancuso, *Journal of Consulting and Clinical Psychology*, 1972, *39*, 1 - 5

CROCETTI, G. M., SPIRO, H. R., & SIASSI, I., *Contemporary attitudes toward mental illness*, Pittsburgh: University of Pittsburgh Press, 1974

CRUMPTON, E., WEINSTEIN, A. D., ACKER, C. W., & ANNIS, A. P., How patients and normals see the mental patient, Journal of Clinical Psychology, 1967, 23, 46 - 49

CUMMING, E., & CUMMING, J., Closed ranks: An experiment in mental health, Cambridge: Harvard University Press, 1957

CUMMING, J., & CUMMING, E., Ego and Milieu: Theory and practice of environmental therapy, New York: Atherton, 1966

CZAPLICKA, M. A., Aboriginal Siberia: a study in social anthropology, Oxford: Clarendon Press, 1914

DAVIES, A. E., DINITZ, S., PASAMANICK, B., The prevention of hospitalization in schizophrenia: Five years after an experimental program, American Journal of Orthopsychiatry, 1972, 42, 375 - 388

DAVIS, Kingsley., Mental hygiene and the class structure, Psychiatry, 1938, 1, 55 - 65

DECKER, J. B., & STUBBLEBINE, J. M., Crisis intervention and prevention of psychiatric disability; a follow-up study, American Journal of Psychiatry, 1972, 129, 101 - 105

DENNER, B., & HALPRIN, F., Ex-hospital clients evaluate their aftercare experiences, American Journal of Community Psychology, 1975, 3, 161 - 171

DEUTSCH, A., The shame of the states, New York: Harcourt, Brace, 1968

DEUTSCH, A., The mentally ill in America, New York: Columbia University Press, 1937

DEYKIN, E., The reintegration of the chronic schizophrenic patient discharged to his family and community as perceived by the family, Mental Hygiene, 1961, 45, 235 - 246

DIETER, J. B., HANFORD, D. B., HUMMEL, R. T., & LUBACH, J. E., Brief inpatient treatment - A pilot study, Mental Hospital, 1965, 16, 95 - 98

DI FRANCO, J., A collection of principles and guides, New York: New York State College of Agriculture at Cornell University, 1958

DOHRENWEND, B. P., Social status and psychological diorder: An issue of substance and an issue of method, *American Sociological Review*, 1966, *31*, 14 - 34

DOHRENWEND, B. P., BERNARD, V. W., & KOLB, L. C., The orientations of leaders in an urban area toward problems of mental illness, *American Journal of Psychiatry*, 1962, *118*, 683 - 691

DOHRENWEND, B. P., & CHIN-SHONG, E., Social status and attitudes towards psychological disorder: The problem of tolerance of deviance, *American Sociological Review*, 1967, *32*, 417 - 433

DORKEN, H., A dimesnional strategy for community focused mental health services, in ROSENBLUM, Gershen., (ed.), *Issues in community psychology and preventive mental health*, New York: Behavioral Publications, Inc., 1971

DUNHAM, A., Some principles of community development, *International Review of Community Development*, *11*, 141 - 181

DUNHAM, A., *The new community organization*, New York: Thomas Y. Crowell Company, 1970

DUNHAM, H. W., Community psychiatry: The newest therapeutic bandwagon, *Archives of General Psychiatry*, 1965, *12*, 303 - 313

DUNHAM, H. W., Community psychiatry: The newest therapeutic bandwagon, *Current Issues in Psychiatry*, *I*., New York: Science House, 1967

DUNHAM, H. W., *Community and schizophrenia in an epidemiological analysis*, Detroit: Wayne State University Press, 1965

DURRELL, J., ARNSON, A., & KELLAM, S. G., A community-oriented therapeutic milieu, *Medical Annals*, D.C., 1965, *34*, 468 - 474

EATON, J. W., & WEIL, R. J., The mental health of the Hutterites, in SCHEFF, Thomas J., *Mental illness and social process*, New York: Harper and Row, 1967

EHRLICH, D., & SABSHIN, Melvin., A study of sociotherapeutically oriented psychiatrists, *American Journal of Orthopsychiatry*, 1964, *34*, 469 - 486

EISENBERG, L., Possibilities for a preventive psychiatry, *Pediatrics*, 1962, *30*, 815 - 828 (a)

EISENBERG, L., If not now, when? American Journal of Orthopsychiatry, 1962, 32, 781 - 793 (b)

EISENBERG, L., Preventive psychiatry, in RYTAND, D., & CREGER, W. P., (eds.), *Annual review of medicine, vol. 13*, Stanford: Annual Reviews, Inc., 1962, pp. 343 - 357

ELLSWORTH, R. B., A behavioral study of staff attitudes toward mental illness, *Journal of Abnormal Psychology*, 1965, *70*, 194 - 200

ELLSWORTH, R. B., FOSTER, L., CHILDERS, B., ARTHUR, G., & KROCKER, D., Hospital and community adjustment as perceived by psychiatric patients, their families, and staff, *Journal of Consulting and Clinical Psychology Monograph*, 1968, *32*

ELLSWORTH, R. B., DICKMAN, H. R., & MARONEY, R. J., Characteristics of productive and unproductive unit systems in V.A. psychiatric hospitals, *Hospital & Community Psychiatry*, 1972, *23*, 261 - 271

ELSARRAG, M. E., Psychiatry in the northern Sudan: A study in comparative psychiatry, *British Journal of Psychiatry*, 1968, *114*, 945 - 948

ERICKSON, R. C., Outcome studies in mental hospitals: A review, *Psychological Bulletin*, 1975, *82*, 519 - 540

ERICKSON, R. & PAIGE, A., Fallacies in using length-of-stay and return rates as measures of success, *Hospital & Community Psychiatry*, 1973, *24*, 559 - 561

ERIKSON, E. - quoted in WHITE, Robert W., *The abnormal personality*, New York: Ronald Press, 1956, p. 117

ETZIONI, Amitai., *The active society*, New York: The Free Press, 1968

EYSENCK, H. J., The effects of psychotherapy: an evaluation, *Journal of Consulting Psychology*, 1952, *16*, 319 - 324

EYSENCK, H. J., A short questionnaire for the measurement of two dimensions of personality, *Journal of Applied Psychology*, 1958, *42*, 14

EYSENCK, H. J., (ed.), Behavior therapy and the neuroses,
Glasgow: Pergamon Press, 1960, pp. 4 - 22; and 10 - 13

EYSENCK, H. J., The classification of depressive illness,
British Journal of Psychiatry, 1970, 117, 241 - 250

FAIRWEATHER, G. W., Methods of experimental social innovation,
New York: Wiley, 1967

FAIRWEATHER, G. W., et al., Community life for the mentally ill,
Chicago: Aldine Books, 1969

FAIRWEATHER, G. W., Social psychology in treating mental illness:
An experimental approach,
New York: Wiley, 1964

FARINA, A., GLIHA, D., BOUDREAU, L. A., ALLEN, J., & SHERMAN, M.,
Mental illness and the impact of believing others know about it,
Journal of Abnormal Psychology, 1971, 77, 1 - 5

FARINA, A., & RING, K., The influence of perceived mental illness on interpersonal relations,
Journal of Abnormal Psychology, 1964, 70, 47 - 51

FARNSWORTH, D. L., - quoted in,
LIPSCOMB, W. R., The impact of medicare on psychiatry,
American Journal of Psychiatry, 1968, 124, 910 - 916

FEIGL, H., The "mental" and the "physical", in
FEIGL, H., SCRIVEN, M., & MAXWELL, Grover., (eds.),
Concepts, theories, and the mind-body problem,
Minneapolis: University of Minnesota Press, 1958, pp. 370 - 497

FELIX, R. H., Mental illness: progress and prospects,
New York: Columbia University Press, 1967

FIELD, M. J., The search for security,
Evanston, Ill.,: Northwestern University Press, 1960

FINLAY, D. G., Alcoholism is an illness. Right? Wrong?
Canada's Mental Health, 1974, xxii, 9 - 11

FLETCHER, R. C., Measuring community mental health attitudes by means of hypothetical case descriptions,
Social Psychiatry, 1969, 4, 152 - 156

FOLEY, J. P., jr., The criterion of abnormality,
Journal of Abnormal and Social Psychology, 1935, 30, 279 - 290

FORREST, A. D., Can we afford mental health?
Scot. Medical Journal, 1967, 12, 129

FORSTENZER, Hyman., Problems in relating community programs to state hospitals,
American Journal of Public Health, 1961, 51

FORTUNE, R. F., Sorcerers of Dobu,
New York: Routledge, 1932

FOUCAULT, M., Madness and civilization: A history of insanity in the age of reason,
New York: Random House, 1965

FOWLER, H. W., & FOWLER, F. G., (eds.), The concise Oxford dictionary of current English,
Oxford: Clarendon Press, 1964

FREEDMAN, A. M., KAPLAN, H. I., & SADOCK, B. J., (eds.),
Comprehensive textbook of psychiatry, vols. 1 & 2,
Baltimore: Williams and Wilkins, 1972, 2nd. ed., 1975

FREEMAN, H. E., Attitudes toward mental illness among relatives of former patients,
American Sociological Review, 1961, 26, 59 - 66

FREEMAN, H. E., & KASSEBAUM, C. G., The relationship of education and knowledge to opinions about mental illness,
Mental Hygiene, 1960, 44, 43 - 47

FREEMAN, H., & SIMMONS, O., Mental patients in the community: Family settings and performance levels,
American Sociological Review, 1958, 23, 147 - 154

FREEMAN, H., & SIMMONS, O., Social class and posthospital performance levels,
American Sociological Review, 1959, 24, 345 - 351

FREEMAN, H., & SIMMONS, O., The mental patient comes home,
New York: John Wiley & Sons, Inc., 1963

FREEMAN, S.J. J., Mental health and the Hastings report,
Canada Mental Health, 1975, 3 - 5

FRIED, M., Social problems and psychopathology, in
DUHL, L., (ed.), Urban America and the planning of mental health services,
New York: Group for the Advancement of Psychiatry, 1964

GALDSTON, I., (ed.), *Historic derivations of modern psychiatry*,
New York: McGraw-Hill, 1967

GALLAGHER, A., *Plainville fifteen years later*,
New York: Columbia University Press, 1961

GARIN, G., *Americans view their mental health*,
New York: Basic Books, 1960

GARTNER, A., *Paraprofessionals and their performance*,
New York: Praeger, 1971.

GEERTZ, C., Ideology as a cultural system, in
APTER, D. E., (ed.), *Ideology and dissent*,
New York: Free Press, 1964

GELLER, J. J., The relationship between psychoanalysis and the
community mental health program,
Perspectives in Psychiatric Care, 1975, *3 - 13*, 113 - 118

GILBERT, D. C., & LEVINSON, D. J., Ideology, personality, and
institutional policy in the mental hospital,
Journal of Abnormal and Social Psychology, 1956, *53*, 263 - 271

GILBERT, D. C., & LEVINSON, D. J., "Custodialism" and "humanism"
in staff ideology, in GREENBLATT, M., LEVINSON, D. J.,
& WILLIAMS, R. H., (eds.), *The patient and the mental
hospital*,
Glencoe, Ill.,: Free Press, 1957, pp. 20 - 35

GIOVANNONI, J. M., & ULLMANN, L. P., Conceptions of mental health
held by psychiatric patients,
Journal of Clinical Psychology, 1963, *19*, 398 - 400

GLICK, I., & HALEY, J., *Family therapy and research: An annotated
bibliography*,
New York: Grune & Stratton, 1971

GLICK, I., HARGREAVES, & GOLDFIELD,
American Journal of Psychiatry, 1975, *132*, 385 - 390

GLIDEWELL, J. C., & SWALLOW, C. S., *The prevalence of maladjustment
in elementary schools: A report prepared for the Joint
Commission on the mental health of children*,
Chicago: University of Chicago Press, 1969

GOFFMAN, E., *Asylums*,
Garden City, N.Y.: Doubleday, 1961

GOFFMAN, E., *Stigma, notes on the management of a spoiled identity,* Englewoods Cliffs, N.J.: Prentice-Hall, Inc., 1963

GOLDBLATT, P. B., BERBERIAN, R. M., GOLDBERG, B., et al., Catchmenting and the delivery of mental health services, *Archives of General Psychiatry*, 1973, *28*, 478 - 482

GOLDSTON, S. E., (ed.), *Concepts of community psychology: A framework for training,* Bethesda, Md.: US. DHEW, Public Health Service Publication, no. 1319, 1965

GOLDSTON, S. E., Mental health education in a community mental health center, *American Journal of Public Health*, 1968, *58*, 693 -699

GOULDNER, A. W., Reciprocity and autonomy in functional theory, in GROSS, L., (ed.), *Symposium on sociological theory,* New York: Harper & Row, 1959, pp. 241 - 270

GOVE, W. R., Societal reaction as an explanation of mental illness: an evaluation, *American Sociological Review*, 1970, *35*, 873 - 884

GREENBLATT, M., & GLAZIER, E., The phasing out of mental hospitals in the United States, *American Journal of Psychiatry*, 1975, *132*, 1135 - 1140

GREENBLATT, M., & LEVINSON, D. J., Mental hospitals, in WOLMAN, B., (ed.), *Handbook of clinical psychology,* New York: McGraw-Hill, 1965, pp. 1343 - 1359

GREER, Scott A., *The emerging city; Myth and reality,* New York: Free Press, 1962

GRIFFITH, C. R., & LIBO, L. M., *Mental health consultants: Agents of community change,* San Francisco: Jossey-Bass, 1968

GROSSER, C., HENRY, W. E., & KELLY, J. G., (eds.), *Nonprofessionals in the human services,* San Francisco: Jossey-Bass, 1969

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *The preclinical teaching of psychiatry,* Report No. 54, New York, 1962

GRUENBERG, E., The social breakdown syndrome: Some origins, *American Journal of Psychiatry*, 1967, *123*, 1481 - 1489

GUERNEY, B., Filial therapy: Description and rationale,
Journal of Consulting Psychology, 1964, 28, 304 - 310

GUEST, R. H., Organizational change,
Homewood, Ill.: Richard D. Irwin, 1962

GURIN, G., VEROFF, J., & FELD, S., Americans view their mental health: A nationwide interview survey,
New York: Basic Books, 1960

GURSSLIN, O., HUNT, R. G., & ROACH, J. L., Social class and the mental health movement, in RIESSMAN, F., COHEN, J., & PEARL, A., (eds.), Mental health and the poor,
New York: Free Press, 1964, pp. 57 - 67

HADFIELD, J. A., Psychology and mental health,
London: Allen and Unwin, 1950

HANSELL, N., & BENSON, M. L., Interrupting long-term patienthood: A cohort study,
Archives of General Psychiatry, 1971, 24, 238 - 243

HANSEN, K. H., Planning for changes in education, in MORPHET, E. L., & RYAN, C. O., Planning and effecting needed changes in education,
Denver: Publishers Press, 1967

HASTINGS, J.E., The community health centre in Canada, vol. 1,
Ottawa: Information Canada, 1972

HAWKS, David., Community care: An analysis of assumptions,
British Journal of Psychiatry, 1975, 127, 276 - 285

HAYLETT, C. H., & RAPOPORT, L., Mental health consultation, in Bellak, L., (ed.), Handbook of community psychiatry and community mental health,
New York: Grune & Stratton, 1964, pp. 319 - 339

HENDERSON, J., Community transference: With notes on the clinic-community interface,
Journal of American Academy of Psychoanalysis, 1974, 2, 113

HENRY, J., My life with the families of psychotic children (1964), in HANDEL, Gerald., The psychosocial interior of the family,
Chicago: Aldine - Atherton, 1967, pp. 30 - 46

HERZ, M. I., ENDICOTT, J., SPITZER, R. L., & MESNIKOFF, A., Day vs. inpatient hospitalization: A controlled study,
American Journal of Psychiatry, 1971, 127, 1371 - 1382

HILLERY, G., Definitions of community: Areas of agreement, *Rural Sociology*, 1955, *20*, 111 - 124

HILLERY, G., A critique of selected community concepts, *Social Forces*, 1959, *37*, 236 - 242

HINSIE, L. E., & CAMPBELL, R. J., *Psychiatric dictionary*, 4th. ed., New York: Oxford University Press, Inc., 1970

HIRSCHOWITZ, R. G., Dilemmas of leadership in community mental health, *Psychiatric Quarterly*, 1971, *45*, 102 - 116

HOBBS, N., Mental health's third revolution, *American Journal of Orthopsychiatry*, 1964, *34*, 822 - 833

HOGARTHY, G. E., GOLDBERG, S. C., et al., Drug and sociotherapy in the aftercare of schizophrenic patients, *Archives of General Psychiatry*, 1973, *28*, 54 - 64

HOLLINGSHEAD, A. D., & REDLICH, F., *Social class and mental illness*, New York: John Wiley & Sons, Inc., 1958

HOLTZBERG, J. D., & GEWIRTZ, H., A method of altering attitudes toward mental illness, *Psychiatric Quarterly Supplement*, 1963, *37*, 56 - 61

HONIGFELD, G., & GILLIS, R., The role of institutionalization in the natural history of schizophrenia, *Diseases of the Nervous System*, 1967, *28*, 660 - 663

HOWARD, L. A., & BAKER, F., Ideology and role function of nurse in community mental health, *Nursing Research*, 1971, *20*, 450 - 454

HUESSY, H. R., (ed.), *Mental health with limited resources: Yankee ingenuity in low-cost programs*, New York: Grune & Stratton, 1966

HUFFINE, C. L., & CRAIG, T. J., Catchment and community, *Archives of General Psychiatry*, 1973, *28*, 483 - 488

HUGO, H. E., Masterpieces of neoclassicism (p. 8), in MACK, M., (ed.), *World Masterpieces*, *vol. 2.*, New York: W. W. Norton & Company, Inc., 1966

HUNT, J. McV., *Intelligence and experience*, New York: Ronald Press, 1961

HUNTER, R., & MACALPINE, I., *Three hundred years of psychiatry, 1535 - 1860*, London, U.K., Oxford University Press, 1963

INSEL, P. M., & MOOS, R. H., Psychosocial environments: Expanding the scope of human ecology, *American Psychologist*, 1974, *29*, 179 - 188

ISCOE, I., & SPIELBERGER, C. D., (eds.), *Community psychology: Perspectives in training and research*, New York: Appleton-Century-Crofts, 1070

JACKSON, B., Reflections on DSM-II, *International Journal of Psychiatry*, 1969, *7*, 385 - 392

JACOB, T., Family interaction in disturbed and normal families, *Psychological Bulletin*, 1975, *82*, 33 - 65

JAHODA, M., *Current concepts of positive mental health*, Joint Commission on Mental Illness and Health, New York: Basic Books, 1958

JARVIS, P. E., & NELSON, S. E., The therapeutic community and new roles for clinical psychologists, *American Psychologist*, 1966, *21*, 524 - 529

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH: *Action for mental health*, New York: Basic Books, 1961

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH: *Digest of action for mental health*, Final report, Boston, Mass., 1961

JONES, E., *The life and work of Sigmund Freud*, New York: Basic Books, 1955, vol. 3, p. 297

JONES, M., *The therapeutic community: new treatment method in psychiatry*, New York: Basic Books, 1953

JONES, M., Community care for chronic mental patients: The need for a reassessment, *Hospital & Community Psychiatry*, 1975, 26

KAHN, A. J., *Studies in social policy and planning*, New York: Russell Sage Foundation, 1969

KAHN, R., Implications of organizational research for community mental health, in CARTER, J. W., (ed.), *Research contributions from psychology to community mental health*, New York: Behavioral Publications, 1968

KANTOR, D., & GELINEAU, V., Social processes in support of chronic deviance, International Journal of Social Psychiatry, 1965, 11, 280 - 289

KANTOR, D., & LEHR, W., Inside the family, San Francisco: Jossey-Bass, Inc., Publishers, 1975

KAUFMAN, Harold F., Toward an international conception of community, Social Forces, 1959, 38, 8 - 17

KELLY, J. G., The mental health agent in the urban community, in Symposium No. 10, Urban America and the planning of mental health services, New York: Group for Advancement of Psychiatry, 1964 pp. 474 - 494

KELLY, J. G., Ecological constraints on mental health services, American Psychologist, 1966, 21, 535 - 539

KELLY, J. G., Towards an ecological conception of preventive interventions, in CARTER, J. W., (ed.), Research contributions from psychology to community mental health, New York: Behavioral Publications, 1968, pp. 75 - 97

KELLY, J. G., Naturalistic observations in contrasting social environments, in WILLEMS, E. P., & RAUSH, H. L., (eds.), Naturalistic viewpoints in psychological research, New York: Holt, Rinehart, and Winston, 1969, pp. 183 - 199

KELLY, J. G., The quest for valid preventive interventions, in ROSENBLUM, Gershen, (ed.), Issues in community psychology and preventive mental health, New York: Behavioral Publications, Inc., 1971

KENDELL, R. E., The classification of depressive illnesses, Maudsley Monographs 18, New York: Oxford University Press, 1968

KENNISTON, K., How community mental health stamped out the riots (1968 - 1978), Transaction, 1968, 5, 21 - 29

KERLINGER, F. N., Foundations of behavioral research, (2nd. ed.), New York: Holt, Rinehart, and Winston, Inc., 1973

KERNER, Otto., Report of the national advisory commission on civil disorders, New York: Bantam Books, 1968

KESKIMER, A., ZALEMAN, M. J., RUPPERT, F. H., & ULETT, G. A., The foster community: A partnership in psychiatric rehabilitation, *American Journal of Psychiatry*, 1972, *129*, 283 - 288

KESSEL, W. I. N., Who ought to see a psychiatrist? *Lancet*, 1963, *1*, 1092

KIESLER, F. More than psychiatry: A rural program, in SHORE, M. F., & MANNING, F. V., (eds.), *Mental health in the community: Problems, programs and strategies*, New York: Behavioral Publications, 1963, pp. 103 - 120

KIRKS, S. A., & THERRIEN, M. E., Community mental health myths and the fate of former hospitalized patients, *Psychiatry*, 1975, *38*

KISKER, G. W., *The disorganized personality*, New York: McGraw-Hill Book Company, 1964, pp. 234, 292

KLEIN, D. C., *Community dynamics and mental health*, New York: John Wiley & Sons, Inc., 1968

KLEIN, D. C., & LINDEMANN, E., Preventive intervention in individual and family crisis situations, in CAPLAN, G., (ed.), *Prevention of mental disorder in children*, New York: Basic Books, 1961, chapter 13

KLEIN, D. F., Importance of psychiatric diagnosis in prediction of clinical drug effects, *Archives of General Psychiatry*, 1967, *16*, 118 - 126

KLERMAN, G., Current evaluation research on mental health services, *American Journal of Psychiatry*, 1974, *131*, 783 - 787

KUBIE, L. S., Pitfalls of community psychiatry, *Archives of General Psychiatry*, 1968, *18*, 257 - 266

KUHN, T. S., *The structure of scientific revolutions*, Chicago: University of Chicago Press, 1962

LAMB, R., & GOERTZEL, V., The demise of the state hospital - a premature obituary, *Archives of General Psychiatry*, 1972, *26*, 489 - 495

LANGSLEY, D. G., FLOMENHAFT, K., & MACHOTKA, P., Follow-up evaluation of family crisis therapy, *American Journal of Orthopsychiatry*, 1969, *39*, 754 - 759

LANGSLEY, D. G., MACHOTSKA, P., & FLOMENHAFT, K., Avoiding mental hospital admission: A follow-up study, *American Journal of Psychiatry*, 1971, *127*, 1391 - 1394

LANGSTON, R. D., Community mental health centres and community mental health ideology, *Community Mental Health Journal*, 1970, *6*, 387 - 392

LAWRENCE, P. R., & LORSCH, J. W., *Developing organizations: Diagnosis and action*, Reading, Mass.: Addison-Wesley, 1969

LEAVELL, H. R., & CLARK, E. G., *Preventive medicine for the doctor in his community: An epidemiological approach*, 3rd. ed. New York: McGraw-Hill, 1965

LECKER, S., et al., Brief intervention: a pilot walk-in clinic in suburban churches, *Canadian Psychiatric Association Journal*, 1971, *16*, 141 - 146

LEGISLATIVE ASSEMBLY OF ALBERTA, *Bill 83, the mental health act*, Edmonton: Queens Printer, 1972

LEIFER, R., *In the name of mental health*, New York: Science House, 1969

LEMERT, E. M., Paranoia and the dynamics of exclusion, in LEMERT, E. M., (ed.), *Human deviance, social problems, and social control*, Englewood Cliffs, N.J.: Prentice-Hall, 1967, pp. 197 - 211

LEMKAU, P. V., & CROCETTI, G. M., An urban population's opinion and knowledge about mental illness, *American Journal of Psychiatry*, 1962, *118*, 692 - 700

LEMKAU, P. V., & PASAMANICK, B., Problems in evaluation of mental health programs, *American Journal of Orthopsychiatry*, 1957, *27*, 55 - 58

LENK, K. (ed.), *Ideologie*, Neuwied/Rhein: Luchterhand, 1961

LENNARD, H. L., & BERNSTEIN, A., *Patterns in human interaction*, San Francisco: Jossey-Bass, 1969

LEVINE, M., Some postulates of practice in community psychology and their implications for training, in ISCOE, I., & SPIELBERGER, C. D., *Community psychology: Perspectives in training and research*, New York: Appleton-Century-Crofts, 1970

LEVITT, E. E., The results of psychotherapy with children: An evaluation, Journal of Consulting Psychology, 1957, 21, 189 - 196

LEVITT, E. E., Psychotherapy with children: A further evaluation, Behavior Research and Therapy, 1963, 1, 45 - 51

LEVITT, E. E., Research on psychotherapy with children, in BERGIN, A. E., & GARFIELD, S. L., (eds.), Handbook of psychotherapy and behavior change: An empirical analysis, New York: Wiley, 1971, pp. 474 - 494

LEWIS, O., Life in a Mexican village: Tepoztlan restudied, Urbana: University of Illinois Press, 1951

LINDEMANN, E., Symptomatology and management of acute grief, American Journal of Psychiatry, 1944, 101, 141 - 148

LINDEMANN, E., The community - an introduction to the study of community leadership and organization, New York: Association Press, 1921

LOEWENSTEIN, R. M., Psychology of the ego, in ALEXANDER, F., EISENSTEIN, S, & GROTJAHN, M., (eds.), Psychoanalytic pioneers, New York: Basic Books, Inc., 1966

LOOMIS, C. P., Social systems, Princeton, N.J., : D. Van Nostrand Company, Inc., 1960

LYND, R., & LYND, H., Middletown, New York: Harcourt, Brace and World, Inc., 1929

LYND, R., & LYND, H., Middletown in transition, New York: Harcourt, Brace and World, Inc., 1937

MACLEAN, U., Community attitudes to mental illness in Edinburgh, British Journal of Preventive Social Medicine, 1969, 23, 45 - 52

MacMILLAN, D. L., Behavior modification in education, New York: Macmillan, 1973

MADDUX, J. F., Psychiatric consultation in a public welfare agency, American Journal of Orthopsychiatry, 1950, 20, 754 - 764

MALINOWSKI, B., Crime and customs in savage society, New York: Dutton, 1926

MANIS, M., HOUTS, P. S., & BLAKE, J. B., Beliefs about mental illness as a function of psychiatric status and psychiatric hospitalization,
Journal of Abnormal and Social Psychology, 1963, *67*, 226 - 233

MANIS, J. G., HUNT, C. L., BRAWERM, M. J., & KERCHER, L. C., Public and psychiatric conceptions of mental illness,
Journal of Health and Human Behavior, 1965, *6*, 48 -55

MARX, A. J., TEST, M. A., & STEIN, L., Extrahospital management os severe mental illness: Feasibility and effects of social functioning,
Archives of General Psychiatry, 1973, *29*, 505 - 511

MARX, J. H., A multidimensional conception of ideologies in professional arenas: The case of the mental health field,
Pacific Sociological Review, 1969, *12*, 75 - 85

MAY, P. R. A., *The treatment of schizophrenia*,
New York: Science House, 1968

MAY, R., A psychologist looks at mental health in today's world,
Mental Hygiene, 1954, *38*, 1

MAYO, C., HAVELOCK, R., & SIMPSON, D., Attitudes towards mental illness among psychiatric patients and their wives,
Journal of Clinical Psychology, 1971, *27*, 128 - 132

MEAD, M., *Coming of age in Samoa*,
New York: Morrow, 1928

MEAD, M., *Growing up in New Guinea*,
New York: Morrow, 1930

MECHANIC, D., Community psychiatry: Some sociological perspectives and implications, in ROBERTS, L., HALLECK, S., & LOEB, M., (eds.), *Community psychiatry*,
Madison: University of Wisconsin Press, 1966, pp. 201 - 222

MECHANIC, D., Some factors in identifying and defining mental illness, in SCHEFF, T. J., *Mental illness and social process*,
New York: Harper & Row, 1967, pp. 23 - 32

MECHANIC, D., *Mental health and social policy*,
New York: Prentice-Hall, 1968

MEHR, J., Personal style of program implementors: A case study in community mental health failure,
Hospital & Community Psychiatry, 1973, *24*, 406 - 409

MENDEL, W., Effect of length of hospitalization on rate and quality of remission from acute psychotic episodes, *Journal of Nervous & Mental Disorders*, 1966, *143*, 226 - 233

MENDEL, W., & RAPPORT, S., Outpatient treatment for chronic schizophrenic patients, *Archives of General Psychiatry*, 1963, *8*, 190 - 196

MENNINGER, K., - quoted in EATON, J. W., The assessment of mental health, *American Journal of Psychiatry*, 1951, page 85

MENNINGER, K., The unitary concept of mental illness, *Bulletin of Menninger Clinic*, 1958, *22*, 4 - 12

MENNINGER, K., *The vital balance*, New York: Viking Press, 1963

MENNINGER, K., Sheer verbal Mickey Mouse, *International Journal of Psychiatry*, 1969, *7*, 415

MEYER, J. K., Attitudes toward mental illness in a Maryland Community, *Public Health Report*, 1964, *79*, 769 - 772

MICHAEL, D. N., *The unprepared society: Planning for a precarious future*, New York: Basic Books, 1968

MILES, M., (ed.), *Innovation in education*, New York: Teachers College Press, 1964

MILLER, D. C., *Handbook of research design and social measurement*, New York: David McKay Company, Inc., 1970

MILLS, E., *Living with mental illness: A study in East London*, London: Routledge and Kegan Paul, Ltd., 1962

MILTON, O., & WAHLER, R. G., (eds.), *Behavior disorders: perspectives and trends*, (2nd. ed.), Phila delphia: J. B. Lippincott, 1969, pp. 6 - 7

MILTON, T., *Modern psychopathology: A biosocial approach to maladaptive learning and functioning*, Philadelphia: W. B. Saunders Company, 1969

MINAR, D., & GREER, S., *The concept of community*, Chicago: Aldine Books, 1969

MINUCHIN, P., BAER, B., SHAPIRO, E., & ZIMILES, H., *The psychological impact of school experience*, New York: Basic Books, 1969

MOOS, R. H., Conceptualizations of human environments, *American Psychologist*, 1973, *28*, 652 - 665

MORRISON, A. P., SHORE, M. F., & GROBMAN, J., On the stresses of community psychiatry and helping residents to serve them, *American Journal of Psychiatry*, 1973, *130*, 1217 - 1237

MOSHER, L. R., FEINSILVER, D., KATZ, M. M., & WIENCHOWSKI, L. A., *Special report on schizophrenia*, Wahington, D.C.: National Institute of Mental Health - 1970

MURPHY, H. B. M., Methods of evaluating community mental health programs, *Canadian Psychiatric Association Journal*, 1971, *16*, 525 - 532

MURRAY, J. E., Failure of the community mental health movement, *American Journal of Nursing*, 1975, 2034 - 2036

McDOUGALL, W., *Outline of abnormal psychology*, New York: Scribners, 1926

McGEE, R. K., *Crisis intervention in the community*, Baltimore, Md.: University Park Press, 1974

McLUHAN, M., & FIORE Q., *War and peace in the global village*, New York: Bantam Books, 1968

NATIONAL INSTITUTE OF MENTAL HEALTH, MacLENNAN, B. W., QUINN, R. D., & SCHROEDER, D., The scope of community mental health consultation and education, Bethesda, Md.: Dept of Health, Education, and Welfare, 1971, Publication No. (NIH) 74 - 650. Quote on p. 3.

NATIONAL INSTITUTE OF MENTAL HEALTH, *Definitions of terms in mental health, alcoholism, drug abuse, and mental retardation*, Washington, D. C., Dept. Health Education, Welfare, Publication No. (ADM) 74 - 38, 1973, pp. 36 - 37

NISBET, R., Moral values and community, *International Review of Community Development*, 1960, *5*, 82

NISBET, R., *The social philosophers*, New York: Thomas Y. Crowell Company, 1973

NISKANEN, P., & PIKHANEN, T., A comparative study of home treatment, and hospital care in the treatment of schizophrenic and paranoid psychotic patients, *Acta Psychiatrica Scandinavia*, 1971, *47*, 271 - 277

NUNNALLY, J., *Popular conceptions of mental health: Their development and change,* New York: Holt, Rinehar, Winston, 1961

NUNNALLY, J., An overview of the public conception of mental health, in WEINBERG, S. K., (ed.), *The sociology of mental disorders: Analyses and readings in psychiatric sociology,* Chicago: Aldine Publishing Co,, 1967

OLMOSK, K. E., Seven pure strategies of change, *1972 Annual Handbook for Group Facilitators,* University Associates, 1972

O'NEAL, P., & ROBINS, L.N., The relation of childhood behavior problems to adult psychiatric status: A 30 year follow-up of 150 subjects, *American Journal of Psychiatry,* 1958, *114,* 961 - 969

O'NEAL, P., & ROBINS, R. N., Childhood patterns predictive of adult schizophrenia: A 30 year follow-up, *American Journal of Psychiatry,* 1958, *115,* 385 - 391

OVERALL, B., & ARONSON, H., Expectations of psychotherapy in patients of lower socio-economic class, *American Journal of Orthopsychiatry,* 1963, *33,* 422

PAGE, J. D., *Psychopathology: the science of understanding deviance,* Chicago: Aldine-Atherton, Inc., 1971

PASAMANICK, B., SCARPITTI, F. R., & DINITZ, S., *Schizophrenics in* the community, New York: Appleton-Century-Crofts, Inc., 1967

PAUL, G. L., Chronic mental patients: Current status - future directions, *Psychological Bulletin,* 1969, *71,* 87 - 94

PECK, H., KAPLAN, S., & ROMAN, M., Prevention, treatment, and social action: A strategy of intervention in a disadvantaged urban area, *American Journal of Orthopsychiatry,* 1966, *36,* 57 - 69

PERKINS, D. V., & THOMPSON, J. R., An assessment of physicians' attitudes toward community mental health, *Community Mental Health Journal,* 1974, *10,* 282 - 291

PHILLIPS, D., Rejection: A possible consequence of seeking help for mental disorders, *American Sociological Review,* 1963, *28,* 963 - 972

PHILLIPS, D., Rejection of the mentally ill: The influence of behavior and sex, *American Sociological Review*, 1964, *29*, 679 - 687

PHILLIPS, D., Self-reliance and the inclination to adopt the sick role, *Social Forces*, 1965, *43*, 555

PINDERHUGHES, C. A., Pathogenic social structure: A prime target for preventive intervention, *Journal of the National Medical Association*, 1966, *58*, 424 - 429

PITT, R., The concept of family burden, Presented at the annual meeting of the American Psychiatric Association, 1969

POOVATHUMKAL, C. K., Community mental health ideology scale standing of paraprofessionals, *Community Mental Health Journal*, 1973, *9*, 108 - 115

POPLIN, D. E., *Communities*, New York: The Macmillan Company, 1972

POSER, E. G., Strategies for behavioral prevention, in DAVIDSON, P. O., (ed.), *The behavioral management of Anxiety, Depression and Pain*, New York: Brunner/Mazel Publishers, 1976, pp. 35 - 55

POWELL, J. W., & BENNE, K., Philosophies of adult education, in KNOWLES, M. S., (ed.), *Handbook of adult education in the United States*, Chicago: Adult Education Association of the U.S.A., 1960, p. 44

PROGRAM AREA COMMITTEE ON MENTAL HEALTH, *Mental disorders: A guide to control methods*, New York: American Public Health Association, 1962

RABKIN, J. G., opinions about mental illness: A review of the literature, *Psychological Bulletin*, 1972, *77*, 153 - 171

RABKIN, J. G., Public attitudes toward mental illness: A review of the literature, *Schizophrenic Bulletin*, 1974, *10*, 9 - 32

RACHMAN, S., & TEASDALE, J., *Aversion therapy and behavior disorders: An analysis*, Coral Gables, Fla.: University of Miami Press, 1970

RAJ, D. The design of sample surveys,
New York: McGraw-Hill Book Company, 1972

RAMSEY, G. V., & SEIPP, M., Attitudes and opinions concerning mental illness,
Psychiatric Quarterly, 1948, 22, 428 - 444 (a)

RAMSEY, G. V., & SEIPP, M., Public opinions and information concerning mental health,
Journal of Clinical Psychology, 1948, 4, 397 - 406 (b)

RAPOPORT, L., The theory and practice of mental health consultation, by Gerald Caplan, Book Review,
Social Service Review, 1971, 6, 223 - 224

RAPOPORT, R., & RAPOPORT, R. N., New light on the honeymoon,
Human Relations, 1964, 17, 33 - 56

REDFIELD, R., The folk culture of Yucatan,
Chicago: University of Chicago Press, 1941

REDFIELD, R., The little community,
Chicago: University of Chicago Press, 1956

REES, T. P., Back to moral treatment and community care,
Journal of mental Science, 1957, 103, 303 - 313

REEVES, J. W., Body and mind in Western thought,
Hammondsworth, Middlesex, U.K.: Penguin Books, Ltd., 1958

REIFF, R., The ideological and technological implications of clinical psychology, in ANDERSON, L. S., et al. (eds.),
Community psychology,
Boston: Boston University Press, 1966

REIFF, R., Mental health manpower and institutional change, in COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.),
Emergent approaches to mental health problems,
New York: Appleton-Century-Crofts, 1967, pp. 74 - 88

REIFF, R., Social intervention and the problem of psychological analysis,
American Psychologist, 1968, 23, 524 - 531

REIN, M., & MORRIS, R., Goals, structures and strategies for community change, in
Social Work Practice, 1962,
New York: Columbia University Press, 1962, pp. 127 - 145

REISMAN, D. *The lonely crowd: A study of changing American character*,
New Haven: Yale University Press, 1950

RIEDEL, D., BRAUER, L., BRENNER, et al., Developing a system for utilization review and evaluation in community mental health centres,
Hospital & Community Psychiatry, 1971, *22*, 229 - 232

RIESSMAN, F., & HOLLOWITZ, E., The neighborhood service center, an innovation in preventive psychiatry,
American Journal of Psychiatry, 1967, *123*, 1408 - 1412

ROBBINS, E., & ROBBINS, L., Charge to the community: some early effects of a state hospital systems change of policy,
American Journal of Psychiatry, 1974, *131*, 641 - 645

ROBINS, L. N., *Deviant children grow up*,
Baltimore: Williams & Wilkins, 1966

ROBINSON, R., DeMARCH, D. F., & WAGLE, M. K., *Community resources in mental health*,
New York: Basic Books, 1961

ROGERS, E., *Diffusion of innovations*,
New York: Free Press, 1962

ROGERS, R. E., *Organizational theory*,
Boston, Mass.: Allyn and Bacon, Inc., 1975

ROKEACH, M., *The open and closed mind*,
New York: Basic Books, 1960

ROKEACH, M., *Beliefs, attitudes and values: A theory of organization and change*,
San Francisco: Jossey-Bass, Inc., 1968

ROOTMAN, A., & LAFARE, P., Ethnic community,
Psychiatric Quarterly, 1965, *41*, 211 - 221

ROSE, C., Relative's attitudes and mental hospitalization,
Mental Hygiene, 1959, *43*, 194 - 203

ROSENTHAL, D., *Genetic theory and abnormal behavior*,
New York: McGraw-Hill, 1970

ROSSI, A. M., Some pre-world war II antecedents of community mental health theory and practice,
Mental Hygiene, 1962, *46*, 78 - 94

ROTHMAN, J., Three models of community organization practice, in Social Work Practice, 1968, New York: Columbia University Press, 1968, pp. 16 - 47

ROTHMAN, J., Planning and organizing for social change, New York: Columbia University Press, 1974

ROTTER, J. B., Generalized expectancies for internal versus external control of reinforcement, Psychological Monographs, 1966, 80, whole 609

RUDERMAN, A. P., Economic characteristics of community health centres, The community health centre project, vol II, Ottawa: Information Canada, 1972

RYLE, G., The concept of mind, London: Hutchinson, 1949

SALZMAN, L., Developments in psychoanalysis, New York: Grune & Stratton, Inc., 1962, pp. 124 - 125

SANDERS, I. T., The community - an introduction to a social system, New York: The Ronald Press, 1966

SANDERSON, D., & POLSON, R., Rural community organization, New York: John Wiley & Sons, 1939

SANFORD, N., The prevention of mental illness, in WOLMAN, B. (ed.), Handbook of clinical psychology, New York: McGraw-Hill, 1965, pp. 1378 - 1400

SARASON, I. G., & GANZER, V. J., Social influence techniques in clinical and community psychology, in SPIELBERGER, C. D., (ed.), Current topics in clinical and community psychology, vol. I, New York: Academic Press, 1969, pp. 1 - 66

SARASON, S. B., Towards a psychology of change and innovation, American Psychologist, 1967, 22, 227 - 233

SARASON, S. B., The cultures of the school and the problem of change, Boston: Allyn-Bacon, 1971

SARASON, S. B., The creation of settings and the future societies, San Francisco: Josse-Bass, 1972

SARASON, S. B., The psychological sense of community: Prospects for a community psychology, San Francisco: Jossey-Bass, 1974

SARASON, S. B., LEVEINE, M., GOLDENBERG, I., CHERLIN, D.L., & BENNETT, E. M., *Psychology in community settings*, New York: wiley, 1966

SARBIN, T. E., & JUHASZ, J. B., The historical background of the concept of hallucination, *Journal of the History of the Behavioral Sciences*, 1967

SARBIN, T. R., & MANCUSO, J. C., Failure of a moral enterprise: Attitudes of the public toward mental illness, *Journal of Consulting and Clinical Psychology*, 1970, *35*, 159 - 173

SATIR, V., *Conjoint family therapy*, rev. ed., Palo Alto: Scinece and Behavior Books, Inc., 1967

SATIR, V., *Peoplemaking*, Palo Alto: Science and Behavior Books, Inc., 1972

SCHEFF, T. J., *Being mentally ill: A sociological theory*, Chicago: Aldine Publishing Co., 1966

SCHEFF, T. J., *Mental illness and social process*, New York: Harper and Row, 1967

SCHULBERG, H. C., Challenge of human service programs for psychologists, *American Psychologist*, 1972, *27*, 566 - 572

SCOTT, W. A., Research definitions of mental health and mental illness, *Psychological Bulletin*, 1958, *55*, 29 - 45

SCOTT, W. G., & MITCHELL, T. R., *Organization theory: A structural and behavioral analysis*, Homewood, Ill.: Richard Irwin, Inc., and the Dorsey Press, 1972

SEHNERT, F., The community development process within a procedural framework, *Adult Leadership*, 1960, *8*, no. 9

SELBY, S. M., (ed.), *Standard mathematical tables*, 21st., ed., Cleveland, Ohio: The Chemical Rubber Co., 1973

SELIGMAN, C. G., Temperament, conflict and psychosis in a stone age population, *British Journal of Psychology*, 1929, *9*, 187 - 202

SELLING, L. S., *Men against madness*, New York: Garden City Books, 1943

SELLTIZ, C., JAHODA, M., DEUTSCH, M., & COOK, S. W., (eds.), *Research methods in social relations*, New York: Holt, Rinehart and Winston, 1959

SHEEHAN, D. M., & ATKINSON, J., Comparative costs of state hospitals and community based inpatient care in Texas - who benefits most? *Hospital & Community Psychiatry*, 1974, *25*

SHEPARD, H., & BLAKE, R., Changing behavior through cognitive change, *Human Organization*, *21*, 1962, pp. 88 - 96

SIEGLER, M., & OSMOND, H., Models of madness, *British Journal of Psychiatry*, 1966, *112*, 1193 - 1203

SIMON, H. A., *Research frontiers in politics and government*, Washington, D.C.: Brookings, 1955

SINGH, R. K. J., TARNOVER, W., & CHEN, R., *Community mental health consultation and crisis intervention*, Palo Alto, Calif.: National Press Books, 1971

SKAGGS, E. B., The meaning of the term "abnormality" in psychology, *Journal of Abnormal and Social Psychology*, 1933, *28*, 113 - 118

SKINNER, B. F., *Walden two*, New York: The Macmillan Company, 1948, 1962.

SKINNER, B. F., *Science and human behavior*, New York: Macmillan, 1952

SKINNER, B, F., *Beyond freedom and dignity*, New York: Alfred A. Knopff, 1971

SKINNER, B. F., *About behaviorism*, New York: Alfred Knopff, 1974

SKOLNICK, J. H., *The politics of protest*, New York: Ballantine Books, 1969

SMITH, M. B., A revolution in mental health care - A "bold new approach"? *Transaction*, 1968, *5*, 19 - 23

SMITH, M. B., & HOBBS, N., The community and the community mental health centre, *American Psychologist*, 1966, *21*, 499 - 509

SMITH, W. G., & HART, D., Community mental health: A noble failure, Hospital & Community Psychiatry, 1975, 26

SOBEY, F., The nonprofessional revolution in mental health,
New York: Columbia University Press, 1970

SOSKIN, W. F., ROSS, N., & KORCHIN, S. J., The origin of project community: Innovating a social institution for adolescents, Seminars in Psychiatry, 1971, 3, 271 - 287

SOWER, C., et al., Community involvement,
Glencoe, Ill.: The Free Press, 1957

SPECK, R. V., & ATTENAVE, C. L., Social network intervention, in HALEY, J., (ed.), Changing families,
New York: Grune & Stratton, 1971

SPECTER, G. A., & CLAIBORN, W. L., Crisis intervention,
New York: Behavioral Publications, 1973

SPENCE, J. T., UNDERWOOD, B. J., DUNCAN, C. P., & COTTON, J. W., Elementary statistics,
New York: Appleton-Century-Crofts, 1968

SPIELBERGER, C. D., A mental health consultation program in a small community with limited professional and mental health resources, in COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.), Emergent approaches to mental health problems,
New York: Appleton-Century-Crofts, 1967, pp. 214 - 236

STAR, S., Popular thinking in the field of mental health, Survey no. 272,
Chicago: University of Chicago Press, 1950

STARK, W., The sociology of knowledge,
London, U.K.: Collier-Macmillan, 1958

STEIN, M. R., The eclipse of community,
Princeton University Press, 1960

STENGEL, E., Classification of mental disorders, Bulletin WHO, 1960, 21, 601 - 663

STIERLIN, H., Bleuler's concept of schizophrenia: A confusing heritage,
American Journal of Psychiatry, 1967, 123, 996 - 1001

STRAUS, M., Conjugal power structure and adolescent personality, Marriage and the Family, 1962, 24, 19 - 25

STRAUSS, J. S., Diagnostic models and the nature of psychiatric disorder,
Archives of General Psychiatry, 1973, *29*, 445 - 449

STRICKLER, M., Applying crisis theory in a community clinic,
Social Casework, 1965, 150 - 154

SUINN, R. M., *Fundamentals of behavior pathology*,
New York: John Wiley & Sons, Inc., 1970, p. 230

SUSSELMAN, S., The role of the psychiatrist in a probation agency,
Focus, 1950, *29*, 33

SUSSER, M. W., & WATSON, W., *Sociology in medicine*,
London: Oxford University Press, 1962

SUTTLES, G., *The social order of the slum*,
Chicago: University of Chicago Press, 1968

SUTTON, W., & KOLAJA, J., The concept of community,
Rural Sociology, 1960, *25*, 197 - 203

SUTTON, W., & KOLAJA, J., Elements of community action,
Social Forces, 1960, *38*, 325 - 332

SWANN, R. J., A survey of a boarding home program for former mental patients,
Hospital & Community Psychiatry, 1973, *24*, 485 - 486

SWINGLE, P., Relative's concept of mental patients,
Mental Hygiene, 1965, *49*, 461 - 465

SZASZ, T. S,, *The myth of mental illness*,
New York: Hoeber-Harper, 1961

SZASZ, T. S., The myth of mental illness, in SCHEFF, T. J., (ed.), *Mental illness and social process*,
New York: Harper and Row, 1967, pp. 242 - 254

SZASZ, T. S., *The manufacture of madness: A comparative study of the inquisition and the mental health movement*,
New York: Dell, 1970

TABER, M., QUAY, H. C., MARK, H., & NEALEY, V., Disease ideology and mental health research,
Social Problems, 1969, *16*, 349 - 357

TAPLIN, J. R., Crisis theory: Critique and reformulation,
Community Mental Health Journal, 1971, *7*, 13 - 23

THELEN, H. A., *Dynamics of groups at work*,
Chicago: University of Chicago Press, 1954

TISCHLER, G. L., HEINISZ, J., MYERS, J.K., et al.,
Catchmenting and the use of mental health services,
Archives of General Psychiatry, 1972, *27*, 389 - 392

TOKER, E., Mental illness in the white and Bantu population of the Republic of South Africa,
American Journal of Psychiatry, 1966, *123*, 55 - 65

TORREY, E. F., *The death of psychiatry*,
Radnor, Pennsylvania: Chilton Book Company, 1974

TRICKETT, E. J., KELLY, J. G., & TODD, D. M., The social environment of the high school: Guidelines for individual change and organizational redevelopment, in GOLANN, S. E., & EISDORFER, (eds.), *Handbook of community psychology*,
New York: Appleton-Century-Crofts, 1971

TRICKETT, E. J., & MOOS, R. H., The social environment of junior high and high school classrooms,
Journal of Educational Psychology, 1973, *65*, 93 - 102

TRICKETT, E. J., & MOOS, R. H., Personal correlates of contrasting environments: Student satisfaction in high school classrooms,
American Journal of Community Psychology, 1974, *2*, 1 - 12

TURBAYNE, C., *Myth of metaphor*,
New Haven: Yale University Press, 1960

TYHURST, J. S., et al., *More for the mind*,
Toronto: Canadian Mental Health Association, 1963

ULLMANN, L. P., *Institution and outcome: A comparative study of psychiatric hospitals*,
New York: Pergamon Press, 1967

ULLMANN, L.P., & GUREL, L., Size, stafffing and psychiatric hospital effectiveness,
Archives of General Psychiatry, 1964, *11*, 360 - 367

ULLMANN, L. P., & KRASNER, L., *Case studies in behavior modification*,
New York: Holt, Rinehart and Winston, 1965

ULLMANN, L. P., & KRASNER, L., *A psychological approach to abnormal behavior*,
Englewood Cliffs, N.J.: Prentice-Hall, 1969

UNITED NATIONS (Dept. of Economic and Social Affairs), *Popular participation in development: Emerging trends in community development*,
New York: United Nations, 1971

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *The prevention of disability in mental disorders*, Mental health monograph 1 Public health service publication no. 924 Washington: Government Printing Office, 1962

VAN LOON, F. G., Amok and lattah, *Journal of Abnormal and Social Psychology*, 1962, *21*, 434 - 444

VETERAN'S ADMINISTRATION, *The day treatment center organization and therapeutic programming*, Program Guide G-10 M-2 Part X Washington: Veteran's Administration, 1974

VROOMAN, P. C., The power dilemma in citizen participation, *Canadian Welfare*, 1972, *48*, no. 3

WAGENFELD, M. O., The primary prevention of mental illness - a sociological perspective, *Journal of Health and Social Behavior*, 1972, *13*, 195 - 203

WAGENFELD, M. O., ROBIN, S.S., & JONES, D. J., Structural and professional correlates of ideologies of community mental health workers, *Journal of Health and Social Behavior*, 1974, *15*, 199 - 210

WALTON, R. E., Two strategies of social change and their dilemmas, *The Journal of Applied Behavioral Science*, 1965, *1*, 167 - 179

WARREN, R. L., *The community in America*, Chicago: Rand McNally Co., 1963

WARREN, R. L., *Truth, love and social change*, Chicago: Rand McNally and Co., 1971

WARWICK, D. P., & LININGER, C. A., *The sample survey: Theory and Practice*, New York: McGraw-Hill, Inc., 1975

WATERS, M., & NORTHOVER, J., Rehabilitated long-stay schizophrenics in the community, *British Journal of Psychiatry*, 1965, *111*, 258 - 267

WECKOWICZ, T., Depersonalization, in COSTELLO, G. G., *Symptoms of psychopathology: A handbook*, New York: John Wiley & Sons, Inc., 1970, pp. 151 - 166

WEGROCKI, H. J., A critique of cultural and statistical concepts of abnormality, *Journal of Abnormal and Social Psychology*, 1939, *34*, 166 - 178

WEINBERG, S. K., (ed), The sociology of mental disorders: Analyses and readings in psychiatric sociology,
Chicago: Aldine, 1967

WEST, J., Plainville, U.S.A.,
New York: Columbia University Press, 1945

WHOLEY, J. S., SCHANLON, J. W., DUFFY, H. G., FUKUMATO, J. S., & VOGT, L. M., Federal evaluation package,
Washington: The Urban Institute, 1970

WILLIAMS, R. H., (ed.), The prevention of disability in mental disorders,
Washington: US Dept. of HEW, Public Health Service Publication No. 924, 1962

WILLIAMS, R. H., & OZARIN, L. D., Community mental health: An international perspective,
San Francisco: Jossey-Bass, Inc., 1968

WING, J. K., & HAILEY, A. M., (eds.), Evaluating a community psychiatric service: The Camberwell Register, 1964 - 1971
London: Oxford University Press, 1972

WIRT, F. M., & HAWLEY, W. D., (eds.), The search for community power,
New York: Prentice-Hall, Inc., 1968

WOLFENSBERGER, W., The principle of normalization in human services,
Toronto: National Institute on Mental Retardation, 1972

WOLPE, J. A., SALTER, A., & REYNA, L. J., (eds.), The conditioning therapies,
New York: Holt, Rinehart and Winston, 1964

WOODY, R. H., Behavioral problem children in the schools,
New York: Appleton-Century-Crofts, 1969

WORLD HEALTH ORGANIZATION, Expert committee on mental health, report on the second session,
Geneva: WHO - Technical Report Series, No. 31, 1951, p. 4

YAMAMOTO, K., & DIZNEY, H. F., Rejection of the mentally ill: A study of attitudes of student teachers,
Journal of Counselling Psychology, 1967, 14, 264 - 268

YARROW, M., CLAUSEN, J., & ROBBINS, P., The social meaning of mental illness,
Journal of Social Issues, 1955, 11, 33 - 48

?

YARROW, M., SCHWARTZ, C., MURPHY, H., & DEASY, L., The psychological meaning of mental illness in the family, *Journal of Social Issues*, 1955, *11*, 12 - 24

ZILBORG, G., & HENRY, G., *A history of medical psychology*, New York: Norton, 1941

ZIMILES, H., Preventive aspects of school experience, in COWEN, E. L., GARDNER, E. A., & ZAX, M., (eds.), *Emergent approaches to mental health problems*, New York: Appleton-Century-Crofts, 1967, pp. 239 - 251

ZIMMERMAN, in SODDY, K., (ed.), *Mental health and infant development*, London: Routledge and Kegan Paul, 1955, vol 2., p. 215

ZINBERG, N., The mirage of mental health, *British Journal of Sociology*, 1970, *21*, 262 - 272

ZUBIN, J., A cross-cultural approach to psychopathology and its implications for diagnostic classification, in ERON, L. D., (ed.), *The classification of behavior disorders*, Chicago: Aldine Publishing Co., 1966

ZUBIN, J., & KIETZMAN, M. L., A cross-cultural approach to classification in schizophrenia and other mental disorders, in HOCH, P. H., & ZUBIN, J., (eds.), *Psychopathology of schizophrenia*, New York: Grune & Stratton, Inc., 1966

APPENDIX

DATA LISTING

A total of 400 questionnaires were mailed out to two urban centers, the cities of Edmonton, and Wetaskiwin in the province of Alberta:

Edmonton	(approximate population: 500,000)	300	33 = 11 %
Wetaskiwin	(approximate population: 10,000)	100	18 = 18 %
	Total :	400	51 = 12.75 %

It was thought that a significant difference in response rate could exist between a large metropolis and a smaller urban center. A chi-square test (chi-square = 3.31) performed on the data, however, indicated that there is no significant difference between the return rates from the two cities.

Age

Age of respondents ranged from 20 to 75 years (mean = 40.06).
52.94 % of respondents were in age group 20 - 40 years
41.18 % of respondents were in age group 41 - 75 years

Sex

Of 51 subjects responding: 68.63 % (35) were male
29.41 % (15) were female
One subject did not indicate sex.

Marital status

The majority of the respondents were married (60.78 %), and approximately one quarter were single (25.49 %):

	Male		Female		
	Edmt.	Wetask.	Edmt.	Wetask.	Total
Single	8		4	1	13 (25.49 %)
Married	14	11	5	1	31 (60.78 %)
Widowed/Divorced	1	1		3	5 (9.80 %)
Other (e.g. separated)			1		1 (1.96 %)
	23	12	10	5	51

One respondent (Wetask) did not indicate marital status

Female:Male ratio was 1:2.33

Income group

Respondents (48) were found to be in eight income groups with the majority in the group earning more than $ 14,000 per annum. Three respondents did not indicate income group:

Income group	f
under $ 4,000	1 (2.08 %)
$ 4,001 -- $ 6,500	3 (6.25 %)
$ 6,501 -- $ 8,000	2 (4.17 %)
$ 8,001 -- $ 9,500	1 (2.08 %)
$ 9,501 -- $ 11,000	6 (12.50 %)
$ 11,001 -- $ 12,500	2 (4.17 %)
$ 12,501 -- $ 14,000	3 (6.25 %)
$ 14,001 -- and over	30 (62.50 %)

Not known: Three respondents = 5.88%

Thus it can be seen that:

8.33 % earned $ 6,500 or less per annum
22.92 % earned between $ 6,500 and $ 12,500 per annum
68.75 % earned $ 12,500 and more per annum

Therefore, approximately one-third of the respondents were found to be earning below the average income for Canadians. The average weekly income for Canadians, May 1977: $ 248.05, or per annum $ 12,898.60 (Source: Statistics Canada, Infomat, 1977, 11-002E).

Correlations significant at the 1 % level were found as follows:

Income group ----- Views of hospital committal and its consequences r = .4409

Correlations significant at the 5 % level were found as follows;

Income group ---- Social Distance r = -.3322
---- Personal dread of mental illness r = .3396
---- The contagion of mental illness r = .3119
---- Explicit sympathy for the m. ill r = .3690
---- Need of treatment, descript. D r = -.3312
---- Need of treatment, descript. F r = -.3180
---- Is something wrong, descrip. G r = -.3265
---- Need of treatment, descript. G r = -.3594

Schooling

47 of the respondents indicated years of schooling received. Four respondents did not offer this information.

Respondents with elementary schooling	---- 4	(8.51 %)
high school schooling	--- 16	(34.04 %)
college schooling	---- 16	(34.04 %)
beyond college	---- 11	(23.40 %)

Correlations significant at the five per cent level were found as follows:

Years of schooling ---- Perceived causes of mental illness r = .3166
---- Mode of referral, descript. C r = .2955
---- Need of treatment, descript. D r =-.2946

Community Mental Health Ideology Scale

All subjects (51) responded to this scale and the full scores ranged from 100 to 257.

Possible range: 38 - 266 (midscore: 152)
Edmonton : 100 - 257 (midscore: 178.5) Mean: 185.7 SD 26.58
Wetaskiwin : 104 - 233 (midscore: 153.5) Mean: 183.4 SD 19.17

Total : 100 - 257 (midscore 178.5) Mean: 184.9 SD 32.37

CMHI scores distributed in quartiles:

Score	f	Quartile
210 - 266	12 (25.53 %)	IV
153 - 209	30 (58.82 %)	III
96 - 152	9 (17.65 %)	II
38 - 95	0 --	I

42 respondents obtained CMHI scores lying in the upper two quartiles, i.e. 82.35 % of respondents in upper two quartiles, and
25.53 % of respondents in the highest quartile.

Correlation between CMHI scale scores and female/male grouping:
Chi-aquare test revealed no significant difference between male/female scores,; chi-square = 2.09
Edmt. Male 4237 (23); Mean = 184.22 Female 1891 (10); Mean = 189.1
Wetask. 2335 (12); Mean = 194.58 967 (6); Mean = 161.2

Correlations significant at the one per cent level were found as follows:

CMHI scale ---- Social Distance r = -.5073
---- View of hosp. committal and consequences r = .4910
---- Perceived public tolerance to mentally ill r = .5134

Correlations significant at the five per cent level were found as follows:

CMHI scale ---- The contagion of mental illness r = .3096
---- Is anything wrong?, descript. B r = -.3309
---- Is it mental illness?, descript. B r = -.3124
---- Mode of referral, descript. E r = .3472
---- Is anything wrong?, descript. F r = -.3372
---- Is anything wrong?, descript. K r = -.3230
---- Need of treatment, descript. K r = -.3345

__Maclean Opinion and Attitude Statements__

This instrument consisted of 47 statements. From these, by grouping together related statements, were derived eight sub-scales as here indicated:

Sub-scale (1) Social Distance
(2) View of hospital committal and its consequences
(3) Perceived public tolerance of the mentally ill
(4) Personal dread of mental illness
(5) Perceived causes of mental illness
(6) The potential danger of the mentally ill
(7) The contagion of mental illness
(8) Explicit sympathy for the mentally ill

(1) Social acceptability of the ex-mental patient (Social Distance)

Possible range: 7 - 49
Edmonton: 7 - 36; Mean 21.56; SD 8.73
Wetaskiw: 7 - 45; Mean 22.50; SD 11.39
Total : 7 - 45; Mean 21.80; SD 9.57

Low score (7 - 27) indicates that the social distance is small, i.e. that the ex-patient is acceptable to the respondent.
High score (28 - 49) indicates that the social distance is great, i.e. that the ex-patient is less acceptable to the respondent.

Total low score: 34 (66.67 %); high score: 17 (33.33 %)

Approximately two-thirds of the total sample indicate greater acceptance of the ex-mental patient

Correlations significant at the one per cent level were found as follows:

Social Distance ---- CMHI score r = -.5073
---- View of hosp. committal and cons. r = -.6202
---- Personal dread of mental illness r = -.4352
---- Potential danger of the mentally ill r = -.5570
---- Severity of situation, descr. A r = -.4003
---- Is anything wrong? descript. B r = .3856
---- Severity of situation, descr. B r = -.4107
---- Is it mental illness?, descr. E r = .5682
---- Is it mental illness?, descr. G r = .4049

Correlations significant at the five per cent level were found as follows:

Social Distance ---- Perceived public tolerance r = -.3094
---- Is it mental illness?, descr. B r = .3150
---- Is anything wrong?, descript. F r = -.3100
---- Is anything wrong?, descript. I r = .3643
---- Income group r = -.3322

Views of hospital committal and its consequences

Possible range 7 - 42
Edmonton : 15 - 36; Mean: 25.30 SD 5.33
Wetaskiwin : 12 - 35; Mean: 24.06 SD 6.41
Total : 12 - 36; Mean: 25.53 SD 5.72

Low score (7 - 24) indicates an inclination toward a custodial view
High score(25 - 42) indicates an inclination toward a community care view.

Total low score: 21 (41.18 %); high score: 30 (58.82 %)

Correlations significant at the one per cent level were found as follows:

Views of hosp. committal & conseq.
---- CMHI score r = .4910
---- Social Distance r = -.6202
---- Income group r = .4409
---- Personal dread of mental illness r = .4496
---- Potential danger of mentally ill r = .5718
---- Is it mental illness?, descr. E r = -.4141
---- Is anything wrong?, descript. K r = -.3836
---- Severity of situation, descr. K r = .4019
---- Need of treatment, descript. K r = -.4228

Correlations significant at the five per cent level were found as follows:

---- Perceived public tolerance r = .2930
---- Perceived causes of mental illn. r = -.3291
---- Severity of situation, descr. A r = .3449
---- Severity of situation, descr. B r = .3636
---- Severity of situation, descr. C r = .3405
---- Is it mental illness?, descr. G r = -.3603

Perceived public tolerance of the mentally ill

Possible range: 1 - 6
Edmonton : 2 - 6; Mean: 4.39
Wetaskiwin : 1 - 6; Mean: 3.78
Total : 1 - 6; Mean: 4.18

Low score (1 - 3) indicates a satisfaction with the existing situation
High score(4 - 6) indicates a dissatisfaction with the existing situation.

Total low score: 18 (35.29 %); high score: 33 (64.71 %)

Approximately two-thirds of the respondents in this study did not think that people nowadays are sufficiently tolerant toward the mentally ill.

Correlations significant at the one per cent level were found as follows:

Perceived public tolerance
---- CMHI score r = .5134
---- Potential danger of ment. ill r = .4122
---- Mode of referral, descript. E r = .3801

Correlations significant at the five per cent level were found as follows:

---- Views of hosp. comm. & conseq. r = .2930
---- Social Distance r = -.3094
---- Severity of situation, descr. I r = .3489
---- Is it mental illness?, descr. K r = .2906

Personal dread of mental illness

Possible range: 1 - 6
Edmonton : 1 - 6; Mean: 3.28
Wetaskiwin : 1 - 6; Mean: 4
Total : 1 - 6; Mean: 3.47

One respondent did not answer this scale

Low score (1 - 3) indicates that respondent has a personal dread of the idea of developing mental illness himself.
High score (4 - 6) indicates that the respondent does not have such dread of himself developing mental illness.

Total low score: 24 (48 %); high score: 26 (52 %)

Correlations significant at the one per cent level were found as follows:

Personal dread ---- Social Distance r = -.4352
---- Views of hosp. comm. & conseq. r = .4496
---- Mode of referral, descr. K r = -.4474
---- Perceived cause of mental illn. r = -.3767

Correlations significant at the five per cent level were found as follows:

---- Potential danger of mentally ill r = .3080

---- Severity of situation, descr. B r = .3114
---- Is anything wrong?, descript. F r = -.3157
---- Income group r = .3396

Perceived causes of mental illness

Possible range: 13 - 91
Edmonton : 28 - 62; Mean: 46.81
Wetaskiwin : 33 - 59; Mean: 44.11
Total : 28 - 62; Mean: 45.84

One respondent (Edmonton) did not respond to this scale

Low score (13 - 52) indicates cause of mental illness to be perceived as being external to the person
High score(53 - 91) indicates cause of mental illness to be perceived as being internal to the person.

Total low score: 43 (86 %); high score: 7 (14 %)

The majority of respondents (86 %) indicate that they perceive causes of mental illness to be external to the person.

Correlations significant at the one per cent level were found as follows:

Perceived causes --- Personal dread r = -.3767

Correlations significant at the five per cent level were found as follows:

Perceived causes --- Years of schooling r = .3166
---- Hosp. comm. & conseq. r = .3291

---- Potential danger of ment. ill r = -.3045

---- Severity of situation, descr. I r = -.3432

The potential danger of the mentally ill

Possible range: 3 - 18

Edmonton	: 6 - 18;	Mean: 10.79
Wetaskiwin	: 3 - 16;	Mean: 9
Total	: 3 - 18;	Mean: 10.31

Low score (3 - 10) indicates the respondent see in the mentally ill a source of possible danger to the community

High score (11 - 18) indicates that the respondent does not see the mentally ill as a source of danger to the community.

Total low score: 28 (54.90 %); high score: 23 (45.10 %)

Correlation significant at the one per cent level was found as follows:

Danger of the mentally ill --- Mode of referral, descr. K r = -.3965

The contagion of mental illness

Possible range: 1 - 6

Edmonton	: 1 - 6;	Mean: 4.03
Wetaskiwin	: 1 - 6;	Mean: 4.72
Total	: 1 - 6;	Mean: 4.63

Low score (1 - 3) indicates an agreement that mental illness can be contagious

High score (4 - 6) indicates a disagreement that mental illness can be contagious.

Total low score: 15 (29.41 %); high score: 36 (70.59 %)

The majority (70.59 %) of the respondents indicated that they did not think close association with mentally ill people would be contagious.

Correlation significant at the one per cent level was found as follows:

Contagion of mental illness	-- Explicit sympathy for the mentally ill	r = .3750

Correlations significant at the five per cent level were found as follows:

Contagion	---- CMHI score	r = .3096
	---- Income group	r = .3119

Explicit sympathy for the mentally ill

Possible range: 2 - 12

Edmonton	: 2 - 12;	Mean: 8.33
Wetaskiwin	: 2 - 12;	Mean: 8.22
Total	: 2 - 12;	Mean: 8.29

Low score (2 - 6) indicates the respondent expresses sympathy for the mentally ill

High score (8 - 12) indicates the respondent does not express sympathy for the mentally ill

Total low score: 12.5 (24.51 %); high score: 37.5 (73.53 %)

The majority (73.53 %) of the respondents disagreed with the statements, thus choosing not to express sympathy for the mentally ill.

Correlation significant at the one per cent level was found as follows:

Explicit sympathy----	Contagion of mental illness	r = .3750

Correlations significant at the five per cent level were found as follows:

Explicit sympathy ---	Income group	r = .3690
-----	Mode of referral, descr. E	r = .3414
-----	Mode of referral, descr. K	r = .3081

Mode of referral questionnaire

This questionnaire consists of ten descriptions of persons suffering from emotional and behavior disorders. Such persons are often met with in the community. A set of five questions were asked for each description:

(a) Would you say there is anything wrong with this person ?
(b) Would you say this person has some kind of mental illness ?
(c) Do you think this is a mild, moderate, or severe disturbance ?
(d) Do you think this person is in need of some kind of treatment?
(e) To where would you refer this person ?

For the last question the respondent was offered the following options:

(1) General Hospital
(2) Local Health Department
(3) Provincial Mental Hospital
(4) Family Doctor
(5) Private Psychiatrist
(6) Clergy
(7) Police Agency/Court

(8) Employer
(9) Parents
(10) Child Guidance Center
(11) Friends
(12) Social Service Agency
(13) Other (please specify), - this was an open category

Only for the descriptions H, and I, is the family doctor the fourth choice; otherwise the family doctor and the private psychiatrist are within the first three choices.

Table I, and II indicate the frequencies of responses to the MOR questionnaire, and utilization of referral options.

The pages following tables I, and II, indicate significant correlations for each of the ten descriptions of persons suffering from emotional and behavior disturbance. These are extracted from a correlation matrix giving the Pearson Correlation Coefficients for fiftyone subjects over sixtyone variables.

The matrix was obtained through use of the University of Alberta computer service, using program FOPPS MAIN 181.

Values of r at the five per cent and one per cent level of significance were obtained from consultation of abbreviated tables of such values in:

SPENCE, J. T., UNDERWOOD, B. J., DUNCAN, C. P., & COTTON, J. W.,
Elementary statistics,
New York: Appleton-Century-Crofts, 1968
page 236

TABLE I

Frequencies for the mode of referral questionnaire

		A	B	C	D	E	F	G	H	I	K
Is anything wrong with this person	yes	50	46	39	49	28	45	45	32	46	38
	no		5	10		21	5	2	15	1	8
	?	1		2	2	2	1	4	4	4	5
Is it some kind of mental illness?	yes	49	40	24	27	14	23	34	17	38	19
	no	1	10	23	21	32	25	12	27	9	26
	?	1	1	4	3	5	3	5	7	4	6
Is this disturbance: ?	mild	5	24	33	10	31	13	17	26	2	19
	moderate	18	15	9	19	3	21	22	9	10	15
	severe	27	10	1	17	-	6	4	7	31	4
	?	1	2	8	5	17	11	8	9	8	13
Is person in need of some kind of treatment ?	yes	50	45	33	46	26	43	43	38	45	36
	no	1	5	11	1	20	4	1	7	-	4
	?	-	1	7	4	5	4	7	6	6	11
Referral to:											
General Hospital		1			1						
Local Health Dept.		2	4	1	5	4	2	1	1	3	1
Prov. Mental Hosp.		12	3	1	1		1	3	1	10	1
Family Doctor		10	11	21	13	9	2	16	5	8	6
Priv. Psychiatrist		18	20	9	7	13	7	22	9	13	8
Clergy		1		2	2		1	1		2	2
Police Agency		2									
Employer					1						
Parents			2			1	5		13		4
Child Guidance Center			2				28		14		12
Friends			1	1							
Soc. Service Agency		4	4	3	13	1	2	1		11	4
Other			3	3	5	2		2			4
? or no response			1	10	3	20	3	4	8	4	9

TABLE II

Utilization of referral options
(Ranking High -- Low)

DESCRIPTION												1st. choice	(4)+(5)
A --	Option No.	5	3	4	12	2	7	6	1			5(35.29 %)	54.90 %
	Frequency	18	12	10	4	2	2	1	1				
B --	Option No.	5	4	12	2	3	13	9	10	11	?	5(39.22 %)	60.78 %
	Frequency	20	11	4	4	3	3	2	2	1	1		
C --	Option No.	4	?	5	12	13	6	3	11			4(41.18 %)	58.82 %
	Frequency	21	10	9	3	3	2	1	1				
D --	Option No.	12	4	5	2	13	?	6	1	3	8	12(25.49 %)	37.25 %
	Frequency	13	13	7	5	5	3	2	1	1	1		
E --	Option No.	?	5	4	2	13	12	9				5(25.49 %)	43.14 %
	Frequency	20	13	9	4	2	1	1					
F --	Option No.	10	5	9	?	2	4	12				10(54.90 %)	17.65 %
	Frequency	28	7	5	3	2	2	2					
G --	Option No.	5	4	?	3	13	2	6	12			5(43.14 %)	74.51 %
	Frequency	22	16	4	3	2	1	1	1				
H --	Option No.	10	9	5	?	4	2	3				10(27.45 %)	27.45 %
	Frequency	14	13	9	8	5	1	1					
I --	Option No.	5	12	3	4	?	2	6				5(25.49 %)	41.18 %
	Frequency	13	11	10	8	4	3	2					
K --	Option No.	10	?	5	4	9	12	13	6	2	3	10(23.53 %)	27.45 %
	Frequency	12	9	8	6	4	4	4	2	1	1		

The present correlation matrix with 51 subjects has degrees of freedom (df) = 49. The nearest lower entry in the table is df = 45, which has been used. At df = 45, values of r were found to be:

Five per cent level of significance: r = .288

One per cent level of significance: r = .372

Correlations for the ten descriptions were found to be as follows:

Description A: Paranoid Schizophrenic (male)

Correlations significant at the one per cent level of significance were found as follows:

Is it mental illness	--	Need of treatment	r = 1.0000
Severity of situation	--	Anything wrong, B	r = -.4149
-	--	Severity, descr. B	r = .5060
-	--	Referral for B	r = -.4201
-	--	Mental illness?, C	r = -.4168
-	--	Need of treatment, C	r = -.4135
-	--	Severity, descr. I	r = .4035
-	--	Anything wrong, K	r = -.4154
-	--	Severity, descr. K	r = .4570
-	--	Need of treatment, K	r = -.4059
Referral	--	Referral for desc. E	r = .4494
-	--	Referral for desc. F	r = -.4917

Correlations significant at the five per cent level were found as follows:

Severity of situation	--	Mental illness?	r = -.3113
-	--	Need of treatment	r = -.3079
-	--	Need of treatment, B	r = -.3256
-	--	Anything wrong, C	r = -.3329
-	--	Severity, descr. C	r = .3175
-	--	Mental illness?, E	r = -.3519
-	--	Severity, descr. G	r = .2931

Referral	--	Referral, descr. G	r = -.2911
Is it mental illness?	--	Need of treatment, H	r = .3506
Need of treatment	--	Need of treatment, H	r = .3513

Description B: Simple Schizophrenia (female)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ?	--	Severity, descr. A	r = -.4149
-	--	Mental illness?	r = .6667
-	--	Anything wrong, C	r = .4984
-	--	Need of treatment, C	r = .4548
-	--	Anything wrong, E	r = .3892
-	--	Anything wrong, I	r = .4273
-	--	Need of treatment	r = .7778
Is it mental illness ?	--	Need of treatment	r = .6657
-	--	Anything wrong, C	r = .6211
-	--	Mental illness?, C	r = .4450
-	--	Need of treatment, C	r = .4342
-	--	Mental illness?, D	r = .3937
-	--	Anything wrong, E	r = .3749
Severity of situation	--	Severity, A	r = .5060
-	--	Severity, C	r = .4600
-	--	Mental illness?, E	r = -.4432
-	--	Severity, I	r = .4102
Need of treatment	--	Anything wrong, C	r = .6647
-	--	Need of treatment, C	r = .6187
-	--	Anything wrong, E	r = .3967
-	--	Need of treatment, E	r = .3953
Referral	--	Severity, A	r = -.4201
-	--	Mental illness?, C	r = .4130
-	--	Referral, E	r = .5034

Referral	--	Referral, K	r = .3846

Correlations significant at the five per cent level were found as follows:

Is anything wrong?	--	Anything wrong, F	r = .3333
-	--	Need of treatment, H	r = .2968
-	--	Referral, H	r = -.3526
-	--	Mental illness?, I	r = .3582
-	--	Referral, K	r = .3331
Is it mental illness?	--	Referral	r = .3546
-	--	Mental illness?, E	r = .3592
-	--	Anything wrong, F	r = .3312
-	--	Need of treatment, G	r = .3007
-	--	Referral, H	r = -.3247
-	--	Mental illness?, I	r = .3144
-	--	Referral, K	r = .3303
Severity of situation	--	Anything wrong, C	r = -.3035
-	--	Severity, K	r = .3446
Need of treatment	--	Severity, A	r = -.3256
-	--	Mental illness, C	r = .3647
-	--	Need of treatment, H	r = .2947
-	--	Mental illness?, K	r = .3022
-	--	Referral, K	r = .3331
Severity of situation	--	Referral, F	r = -.2958
-	--	Mental illness?, G	r = -.3184
-	--	Severity, G	r = .3346
Referral	--	Anything wrong, C	r = .3078
-	--	Severity, C	r = -.3402
-	--	Referral, C	r = .3542
-	--	Anything wrong, G	r = .3560
-	--	Need of treatment, G	r = .3423
-	--	Mental illness, K	r = .3126
-	--	Severity, K	r = -.3005

Description C: Anxiety Neurosis (male)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ?	-- Anything wrong, B	r = .4984
-	-- Mental illness?, B	r = -.6211
-	-- Need of treatment, B	r = .6647
-	-- Mental illness?	r = .5311
-	-- Mental illness?, D	r = .3749
-	-- Anything wrong, E	r = .6040
-	-- Need of treatment, E	r = .6221
-	-- Mental illness?	r = .4728
-	-- Need of treatment, K	r = .4166
-	-- Referral, K	r = .3893
Is it mental illness ?	-- Severity, A	r = -.4168
-	-- Mental illness, B	r = .4450
-	-- Referral, B	r = .4130
-	-- Mental illness?, E	r = .4762
-	-- Need of treatment, E	r = .4695
-	-- Mental illness?, K	r = .6331
-	-- Need of treatment	r = .6554
Severity of situation	-- Severity, B	r = .4600
-	-- Mental illness?, E	r = -.4055
-	-- Severity, E	r = .4494
-	-- Mental illness?, H	r = -.4248
-	-- Severity, K	r = .4576
Need of treatment	-- Severity, A	r = -.4135
-	-- Anything wrong, B	r = .4548
-	-- Mental illness?, B	r = .4342
-	-- Need of treatment, B	r = .6187
-	-- Anything wrong, E	r = .5516
-	-- Need of treatment, E	r = .6554
-	-- Referral, E	r = .4515

Need of treatment	--	Need of treatment, H	r = .4901
-	--	Anything wrong, K	r = .3723
-	--	Mental illness?, K	r = .4523
-	--	Need of treatment, K	r = .4862
-	--	Referral, K	r = .4749
Referral	--	Referral, E	r = .5159

Correlations significant at the five per cent level were found as follows:

Is anything wrong ?	--	Severity, A	r = -.3329
-	--	Mental illness?, E	r = .3512
Is it mental illness ?	--	Severity of situation	r = -.2883
-	--	Mental illness?, D	r = .3188
-	--	Anything wrong, E	r = .3015
-	--	Referral E	r = .3106
-	--	Mental illness?, I	r = .3698
-	--	Anything wrong, K	r = .3698
-	--	Need of treatment, K	r = .3430
Severity of situation	--	Hosp. comm. & conseq.	r = .3405
-	--	Severity, A	r = .3175
-	--	Severity, F	r = .2940
-	--	Mental illness?, G	r = .3288
-	--	Severity, G	r = .3716
-	--	Severity, H	r = .3065
-	--	Referral, H	r = -.3148
Need of treatment	--	Anything wrong, F	r = .2894
-	--	Referral, F	r = .2923
Referral	--	Years of schooling	r = .2955
-	--	Referral, B	r = .3542
-	--	Referral, F	r = .3078
-	--	Need of treatment, G	r = .3582
-	--	Mental illness?, I	r = .3148
-	--	Severity, K	r = -.3176

Description D: Alcoholism (male)

Correlations significant at the one per cent level were found as follows:

Is it mental illness?	--	Mental illness, B	r = .3937
-	--	Anything wrong, C	r = .3749
Need of treatment	--	Anything wrong, F	r = .4273
-	--	Need of treatment, F	r = .4827
-	--	Need of treatment, K	r = .4799
Severity of situation	--	Severity, G	r = .3779
-	--	Severity, H	r = .4645
-	--	Referral, I	r = -.4688
Referral	--	Mental illness?	r = .4623

Correlations significant at the five per cent level were found as follows:

Is it mental illness ?	--	Mental illness?, C	r = .3188
-	--	Mental illness?, E	r = .2910
-	--	Severity, K	r = .3202
Severity of situation	--	Mental illness?, F	r = .3089
Need of treatment	--	Years of schooling	r = -.2946
-	--	Income group	r = -.3312
-	--	Anything wrong, K	r = .3235
Referral	--	Referral, E	r = .2948
-	--	Mental illness?, H	r = .3027
-	--	Anything wrong, K	r = .2969
-	--	Need of treatment, K	r = .3245

Description E: Compulsive Phobic Neurosis (female)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ?	--	Anything wrong, B	r = .3892
-	--	Mental illness?, B	r = .3749
-	--	Need of treatment, B	r = .3867
-	--	Anything wrong, C	r = .6040
-	--	Need of treatment, C	r = .5516
-	--	Mental illness?	r = .4335
-	--	Need of treatment	r = .6796
Is it mental illness ?	--	Social Distance	r = .5682
-	--	Hosp. comm.& conseq.	r = -.4141
-	--	Severity, B	r = -.4432
-	--	Mental illness?, C	r = .4762
-	--	Severity, C	r = -.4055
-	--	Severity	r = -.3922
-	--	Need of treatment	r = .4773
Severity	--	Severity, C	r = .4494
Need of treatment	--	Need of treatment, B	r = .3953
-	--	Anything wrong, C	r = .6221
-	--	Mental illness, C	r = .4695
-	--	Need of treatment, C	r = .6554
-	--	Referral, F	r = .4019
-	--	Referral, K	r = .4188
Severity of situation	--	Severity F	r = .4005
-	--	Severity, G	r = .3765
-	--	Severity, H	r = .3864
-	--	Severity, K	r = .3895
-	--	Referral, K	r = -.3746
Referral	--	Public Tolerance	r = .3801
-	--	Referral, A	r = .4494
-	--	Referral, B	r = .5084
-	--	Need of treatment, C	r = .4515
-	--	Referral, C	r = .5159
-	--	Severity, F	r = -.4508
-	--	Referral, F	r = .4323

Correlations significant at the five per cent level were found as follows:

Is anything wrong? -- Mental illness?, C r = .3015
Is it mental illness? -- Severity, A r = -.3519
- -- Mental illness?, B r = .3592
- -- Anything wrong, C r = .3512
- -- Mental illness?, D r = .2910
Referral -- CMHI score r = .3472
- -- Explicit sympathy r = .3414
- -- Mental illness?, C r = .3106
- -- Referral, D r = .2948

Description F: Juvenile Character Disorder (male)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ? -- Need of treatment, D r = .4273
- -- Anything wrong, G r = .3762
- -- Need of treatment r = .6367
- -- Need of treatment, G r = .5638
- -- Need of treatment, H r = .3769
Is it mental illness? -- Mental illness?, I r = .4677
Severity of situation -- Referral, E r = -.4508
- -- Severity, G r = .5602
Need of treatment -- Need of treatment, D r = .4827
- -- Anything wrong, G r = .3747
- -- Need of treatment, H r = .3754
- -- Need of treatment, G r = .5631
Referral -- Referral, A r = -.4917
- -- Need of treatment, E r = .4019
- -- Referral, E r = .4323
- -- Anything wrong, I r = -.3772

Correlations significant at the five per cent level were found as follows:

Is anything wrong ? -- CMHI score r = -.3372
- -- Social Distance r = .3100
- -- Dread of mental illness r = -.3157
- -- Anything wrong, B r = .3333
- -- Mental illness?, B r = .3312
- -- Need of treatment, C r = .2894
- -- Mental illness?, I r = .3582
Is it mental illness ? -- Mental illness?, D r = .3380
- -- Severity, D r = .3089
- -- Anything wrong r = .3271
- -- Need of treatment r = .3055
- -- Mental illness, G r = .2882
Severity of situation -- Severity, G r = .2940
Need of treatment -- Income group r = -.3180
Referral -- Severity, B r = -.2958
- -- Severity, C r = -.3676
- -- Need of treatment, C r = .2923
- -- Referral, C r = .3078
- -- Referral, I r = .3087
- -- Referral, K r = .3003

Description G: Anxiety Neurosis (female)

Correlations significant at the one per cent level were found as follows:

Is anything wrong? -- Anything wrong, F r = .3762
- -- Need of treatment, F r = .3747
- -- Need of treatment r = .6988
Is it mental illness ? -- Social Distance r = .4049

Severity of situation	-- Severity, D	r = .3779
-	-- Severity, E	r = .3765
-	-- Severity, F	r = .5602
-	-- Severity, H	r = .4649
-	-- Severity, I	r = .3978
-	-- Severity, K	r = .4944
Need of treatment	-- Anything wrong, F	r = .5638
-	-- Need of treatment, F	r = .5631

Correlations significant at the five per cent level were found as follows:

Is anything wrong ?	-- Income group	r = -.3265
-	-- Referral, B	r = .3560
-	-- Referral, I	r = .3640
-	-- Mental illness?	r = .3589
-	-- Referral	r = .3450
Is it mental illness ?	-- Hosp. comm. & conseq.	r = -.3623
-	-- Severity, B	r = -.3184
-	-- Severity, C	r = -.3288
-	-- Mental illness?, E	r = .3216
-	-- Mental illness?, F	r = .2882
-	-- Severity	r = -.2975
Severity of situation	-- Severity, A	r = .2931
-	-- Severity, B	r = .3346
-	-- Severity, C	r = .3716
Need of treatment	-- Income group	r = -.3594
-	-- Mental illness?, B	r = .3007
-	-- Referral, B	r = .3423
-	-- Referral, C	r = .3582
-	-- Mental illness?, I	r = .3492
Referral	-- Referral, A	r = -.2911
-	-- Anything wrong, K	r = .3010
-	-- Mental illness?, K	r = .2992

Description H: Exhibitionism (male)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ?	--	Mental illness?	r = .5388
-	--	Severity	r = -.4016
-	--	Need for treatment	r = .5381
Is it mental illness ?	--	Severity, C	r = -.4248
-	--	Mental illness, K	r = .4336
-	--	Severity	r = -.4747
Severity of the situation	--	Severity, D	r = .4645
-	--	Severity, E	r = .3864
-	--	Referral	r = -.5342
Need for treatment	--	Need for treatment, C	r = .4901
-	--	Anything wrong, F	r = .3769
-	--	Need for treatment	r = .3754
Referral	--	Severity, I	r = -.3730

Correlations significant at the five per cent level were found as follows:

Is it mental illness ?	--	Referral, D	r = .3027
Need of treatment	--	Referral, K	r = .3066
-	--	Mental illness?, A	r = .3506
-	--	Need of treatment, A	r = .3513
-	--	Anything wrong, B	r = .2968
-	--	Need of treatment, B	r = .2947
Severity of situation	--	Severity, C	r = .3065
-	--	Severity, K	r = .3433
-	--	Need of treatment, K	r = .3039
Referral	--	Anything wrong, B	r = -.3526
-	--	Mental illness?, B	r = -.3247
-	--	Severity, C	r = -.3148

Description I: Neurotic Depression (female)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ? -- Anything wrong, B r = .4273
- -- Referral, F r = -.3772
Is it mental illness ? -- Mental illness?, F r = .4677
Severity of the situation -- Severity, A r = .4035
- -- Severity, B r = .4102
- -- Severity, G r = .3978
- -- Severity, K r = .3934
- -- Referral, H r = -.3730
Referral -- Severity, D r = -.4688

Correlations significant at the five per cent level were found as follows:

Is anything wrong ? -- Social Distance r = .3643
- -- Mental illness ? r = .3030
Is it mental illness ? -- Anything wrong, B r = .3582
- -- Mental illness?, B r = .3144
- -- Mental illness?, C r = .3698
- -- Referral, C r = .3148
- -- Anything wrong, F r = .3582
- -- Need of treatment, G r = .3492
Severity of the situation -- Tolerance r = .3489
- -- Perceived causes r = -.3432
Referral -- Referral, F r = .3087
- -- Anything wrong, G r = .3640

Description K: Drug Dependency (male)

Correlations significant at the one per cent level were found as follows:

Is anything wrong ?	--	Hosp. comm. & conseq.	r = -.3836
-	--	Severity, A	r = -.4154
-	--	Need of treatment, C	r = .3723
-	--	Need of treatment	r = .7237
Is it mental illness ?	--	Anything wrong, C	r = .4728
-	--	Mental illness?, C	r = .6331
-	--	Need of treatment, C	r = .4523
-	--	Referral, D	r = .4623
-	--	Mental illness?, H	r = .4336
Severity of the situation	--	Hosp. comm. & conseq.	r = .4019
-	--	Severity, A	r = .4570
-	--	Severity, C	r = .4576
-	--	Severity, E	r = .3895
-	--	Severity, G	r = .4944
-	--	Severity, I	r = .3934
Need of treatment	--	Hosp. comm. & conseq.	r = -.4228
-	--	Severity, A	r = -.4059
-	--	Anything wrong, C	r = .4166
-	--	Need of treatment, C	r = .4862
-	--	Need of treatment, D	r = .4799
-	--	Anything wrong, K	r = .7237
Referral	--	Dread of mental illn.	r = -.4474
-	--	Danger of mentally ill	r = -.3965
-	--	Referral, B	r = .3846
-	--	Anything wrong, C	r = .3893
-	--	Need of treatment, C	r = .4749
-	--	Severity, E	r = -.3746
-	--	Need of treatment, E	r = .4188

Correlations significant at the five per cent level were found as follows:

Is anything wrong ? -- CMHI score r = -.3230
- -- Mental illness?, C r = .3698
- -- Need of treatment, D r = .3235
- -- Referral, D r = .2969
- -- Mental illness?, E r = .3162
- -- Referral, G r = .3010
- -- Mental illness? r = .3669
Is it mental illness ? -- Public Tolerance r = .2906
- -- Need of treatment, B r = .3022
- -- Referral, B r = .3126
- -- Referral, E r = .3423
- -- Referral, G r = .2992
- -- Severity of situation r = -.3227
Severity of situation -- Severity, B r = .3446
- -- Referral, B r = -.3005
- -- Referral, C r = -.3176
- -- Mental illness?, D r = .3202
- -- Severity, H r = .3433
Need of treatment -- CMHI score r = -.3345
- -- Mental illness?, C r = .3430
- -- Referral, D r = .3245
- -- Severity, H r = .3039
Referral -- Explicit sympathy r = .3081
- -- Anything wrong, B r = .3331
- -- Mental illness?, B r = .3303
- -- Need of treatment r = .3331
- -- Referral, E r = .3408
- -- Referral, F r = .3003
- -- Need of treatment, H r = .3066

CMHI scale Content Analysis

This analysis indicates number of respondents agreeing, disagreeing, and being undecided about each statement in the CMHI scale. Last column indicates how many per cent of those agreeing/disagreeing for each statement, did so strongly.

Statement	Agree	Disagree	Undecided	Agree/Disagree strongly, per cent
1.	43	6	2	25.58
2.	31	17	3	22.58
3.	17	31	3	58.06
4.	44	5	2	43.18
5.	30	19	2	23.33
6.	17	32	2	50.00
7.	44	5	2	31.82
8.	21	28	2	32.14
9.	41	8	2	48.78
10.	45	4	2	33.33
11.	36	13	2	38.89
12.	32	16	3	28.13
13.	45	3	3	42.22
14.	12	36	3	30.56
15.	23	24	4	25.00
16.	39	14	2	20.51
17.	21	27	3	33.33
18.	28	19	4	28.57
19.	46	3	2	58.70
20.	18	30	3	46.67
21.	45	2	4	35.56
22.	45	4	2	46.67
23.	28	22	1	35.71
24.	8	40	3	52.50
25.	42	7	2	40.48
26.	19	29	3	34.48
27.	46	4	1	63.04
28.	33	16	2	24.24
29.	37	13	1	45.95

Statement	Agree	Disagree	Undecided	Agree/Disagree strongly, per cent
30.	15	35	1	34.29
31.	44	5	2	36.36
32.	45	3	3	42.22
33.	23	25	3	24.00
34.	40	7	4	47.50
35.	39	7	5	23.08
36.	21	24	4	16.67
37.	7	40	4	60.00
38.	9	40	2	45.00

75 per cent of the subjects responded in a CMH-Ideology oriented direction to statements:

1, 4, 7, 9, 10, 13, 16, 19, 21, 22, 24, 25, 27, 31, 32, 34, 35, 37, 38.

50 - 75 per cent of the subjects responded in a CMH-ideology oriented direction to statements:

3, 5, 6, 8, 12, 14, 17, 20, 26, 30.

50 - 75 per cent of the subjects responded contrary to a CMH-ideology oriented direction to statements:

2, 11, 18, 23, 28, 29.

Statement 2 - 60.78 per cent of respondents agreed with this statement; nearly one quarter of these did so strongly, indicating an acceptance of traditional diagnosing and treating individual patients as being the optimal way for the professional to function.

Statement 11 - 70.59 per cent of respondents agreed with this statement; approximately one-third did so strongly, indicating a belief in the traditional role of the mental health professional, and not seeing him as responsible for any innovative intervention role.

Statement 18 - 54.9 per cent of respondents agreed with this statement; approximately one quarter did so strongly. Perhaps this indicates a dissatisfaction with the minimal involvement offered citizens ? It may be that the respondents are unaware of existing opportunities for involvement. Being unaware of such involvement, the respondents may be too hasty to agree that such involvement is not worth the effort.

Statement 19 - Of those who agreed, just over half did so strongly, indicating that the traditional view of the locus of mental illness as being within the individual has now strongly changed to the view that the locus of mental illness extends into the family, the community, and the society.

Statement 23 - 54.9 per cent of respondents agreed with this statement; just over one-third doing so strongly. It is possible that the subjects are ignorant of possible service modes of a psychiatrist. How the psychiatrist can function in a non-traditional mode appears not to be known to the respondents. The traditional is too easily accepted.

Statement 27 - It was strongly held that a need exists for helping people not yet sick to develop ways for coping with expected life difficulties.

Statement 28 - There was strong agreement with this statement. This indicates an agreement with a focus on the individual patient, more so than an attempt at changing environmental factors. However, there may have been difficulty in understanding the statement, i.e. it may have been thought to refer to an invasion of a patient's privacy.

Statement 29 - The strong agreement with this statement indicates a strong adherence to the traditional and a surrender of power and and involvement opportunities to the psychiatrist. On the other hand, it may indicate the great ignorance existing among community members as to what they could do in relation to treatment and mental health issues.

Statement 30 - The respondents had no difficulty in deciding that they would prefer to develop prevention programs. However, this statement did not refer to manpower shortage, as did statement 33.

Statement 33 - Agreement and disagreement on this statement was almost even. Community members did not seem to be able to decide on the priority of treatment programs versus preventive programs with reference to a professional manpower shortage, though a slight tendency to prefer prevention programs was indicated.

Ungrouped questions from the Maclean scale, and responses to these:

Statement 5: Mental illness is something it is best not to talk about.
- 13: People who are mentally ill ought not to be allowed to mix with ordinary people
- 16: Rest won't prevent mental disorder

Statement 21: A change of climate seldom helps a developing mental illness
- 30: Mental illness can often be helped by a holiday or change of scene
- 47: I think that in general people should be expected to handle their own problems.

Statement	Subjects agreeing	Subjects disagreeing
5	5	46

Thus there is no indication of mental illness being seen as a taboo topic.

13	4	46

There is no indication of any objection to the mentally ill mixing with those not so afflicted.

16	29	20

Community members tend to feel that rest will not prevent mental disorders, but difference is small between those agreeing and those disagreeing.

21	28	22

Again, there is a tendency to see a change in climate as less likely to help a developing mental illness. Here again, there is only a slight difference between those agreeing and those disagreeing.

30	25	25

As with responses to statements 16, and 21, community members here too are evenly divided as to the merits of the statement.

47	25	25

Again, evenly divided, suggesting apathy and passive-dependent attitude being dominant in the community.

Descriptions utilized in the Mode of Referral questionnaire:

A. Frank Jones is very suspicious; he doesn't trust anybody, and he is sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her because he said, she was working against him too, just like everyone else.

B. Betty Smith is a young woman in her twenties. She has never had a job, and she doesn't want to go out and look for one. She is a very quiet girl; she doesn't talk much to anyone - even her own family - and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays by herself and daydreams all the time, and shows no interest in anything or anybody.

C. George Brown has a good job and he is doing pretty well at it. Most of the time he gets along all right with people, but he is always touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going all right for him, but he can't sleep nights, brooding about the past, and worrying about things that might go wrong.

D. How about Bill Williams ? He never seems to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

E. Mary White seems happy and cheerful; she's pretty, has a good job, and is engaged to marry a young man. She has loads of friends; everybody likes her, and she's always busy, and active. However, she just can't leave home without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one thing about her: She's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

F. A twelve year old boy - Bobby Grey. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from the stores, and taking money from his mother's purse, and he has been playing truant, staying away from school, whenever he could. His parents are very upset about the way he acts, but he pays no attention to them.

G. Ethel Bowden is never completely relaxed; she complains of vague feelings of restlessness and a fear that something is "just around the corner". Although she feels that she should go to work to help pay the family bills, she cannot bring herself to start anything new for fear that something terrible will happen on the job. A few times she has felt "like I couldn't breathe, like I was sealed up in a transparent envelope".

H. George Davison is a 14 year old boy who has been caught for exposing himself to two young girls (four and five years old). He has had no contact with girls of his own age range. Just before the incidence, he was shown some pornographic material by another boy, who told George about his relationship with a girl, thus making George curious about the experience. George has expressed serious doubts about his own sexual adequacy.

I. Virginia Foss, a 33 year old, married woman is at present separated from her husband. She was married at the age of 22, and has six children. She is pale, haggard, and an unkempt woman, living in a rundown apartment without gas or electricity. She says, she is feeling empty and that she cannot see any meaning in life. She has several times attempted suicide by cutting her wrists with a knife or a piece of glass.

K. Robert Harris is 16 years old. Around the house he is restless and uneasy. He is doing poorly in school, seems unable to concentrate properly, but when asked, has an exaggerated sense of his own ability. A recent note from the principal reveals that he has been cutting classes. Most of his spare time he spends with the other boys in the community - this gives him a feeling of belonging and of meaning in life, he says. At times he has a glassy stare, and often talks loud and fast.

General questions presented at the end of the MOR questionnaire:

-Please list facilities that are presently available in your community where individuals with problems similar to those described above could be sent for help.

- In your opinion, what other facilities should be made available in your community to deal with problems similar to those described above ?

- Comments and Suggestions.

The Maclean 47 Opinion and Attitude Statements:

1. The mentally ill are dangerous.
2. The mentally ill should be put away in institutions.
3. People who have become mentally ill are to be pitied.
4. Close association with people who are mentally ill is liable to make a normal person break down.
5. Mental illness is something it is best not to talk about.
6. Most women who were once patients in a mental hospital could be trusted as baby sitters.
7. As soon as someone begins to show signs of mental disturbance they should receive hospital treatment.
8. Mentally ill people seem to live in a different world from the rest of us.
9. Most patients in mental hospitals still have to be kept there against their will.
10. Sometimes it's difficult to think of the mentally ill as ordinary human beings.
11. I would be willing for a member of my family to marry someone who had once been a mental hospital patient.
12. Mentally ill people are ruled more by their emotions than normal people are.
13. People who are mentally ill ought not to be allowed to mix with ordinary people.
14. What the mentally ill need more than anything is to have people show them sympathy.
15. A former mental patient could be trusted in a responsible position, as a lawyer, for example.
16. Rest won't prevent mental disorder.
17. It is generally accidents or illnesses that bring on mental illness.
18. Drink is one of the main causes of mental illness.
19. An unhappy home life is one of the main causes of mental illness.

20. Much mental illness is the result of the strain and stress of present-day living.
21. A change of climate seldom helps a developing mental illness.
22. Job worries can bring on mental illness.
23. Overwork is a big cause of mental illness.
24. Children who are made to feel they are not wanted may develop mental illness when they grow up.
25. Mental illness can be avoided by avoiding gloomy thoughts.
26. Money matters are a big cause of mental illness.
27. One of the main causes of mental illness is lack of moral strength.
28. Sexual overindulgence will end for some people in mental illness.
29. Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital.
30. Mental illness can often be helped by a holiday or change of scene.
31. To develop a mental illness is one of the worst things that could happen to anyone.
32. Few people who enter a mental hospital ever leave it.
33. Many of the mentally ill people who seem to be better will be back for more treatment later on.
34. I would be willing to have a former mental patient living next door.
35. The eyes of the mentally ill are glassy.
36. When a person becomes mentally ill it's just like loosing them altogether.
37. I would be willing to work in a job alongside a former mental patient.
38. People who are mentally ill are liable to commit suicide.
39. The mentally ill don't care about their personal appearance.
40. I would let a former mental patient teach my children.
41. The mentally ill are unreliable, you never know what they will do next.
42. People nowadays are sufficiently tolerant towards the mentally ill.

43. Most patients in mental hospitals nowadays have gone in of their own free will.

44. Women at the change of life are very liable to become mentally ill.

45. A district nurse who had been a mental hospital patient for a time could return to her job afterwards.

46. Sexual self-abuse may cause some young people to become mentally ill.

47. I think that in general people should be expected to handle their own problems.

The Baker-Schulberg 38 statement CMHI scale:

1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.

2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.

3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than to deal with the social conditions which may cause mental illness.

4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.

5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.

6. Such public health programs as primary preventive services are still of little value to the mental health field.

7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.

8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.

9. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.

10. The mental health specialist should seek to extend his effectiveness by working through other people.

11. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.

12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.

13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.

14. The control of mental illness is a goal that can only be attained through psychiatric treatment.

15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.

16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.

17. Our professional mandate is to treat individual patients and not the harmful influences in society.

18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.

19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.

20. Mental health professionals can be concerned for their patient's welfare only when having them in active treatment.

21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.

22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.

23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.

24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success or our work with the mentally ill.

25. The mental health center is only one part of a comprehensive community mental health program.

26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.

27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.

28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.

29. It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.

30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.

31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.

32. Social action is required to insure the success of mental health programs.

33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.

34. Each mental health center should join the health and welfare counsel of each community it serves.

35. The responsible mental health professional should become an agent for social change.

36. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.

37. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.

38. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.